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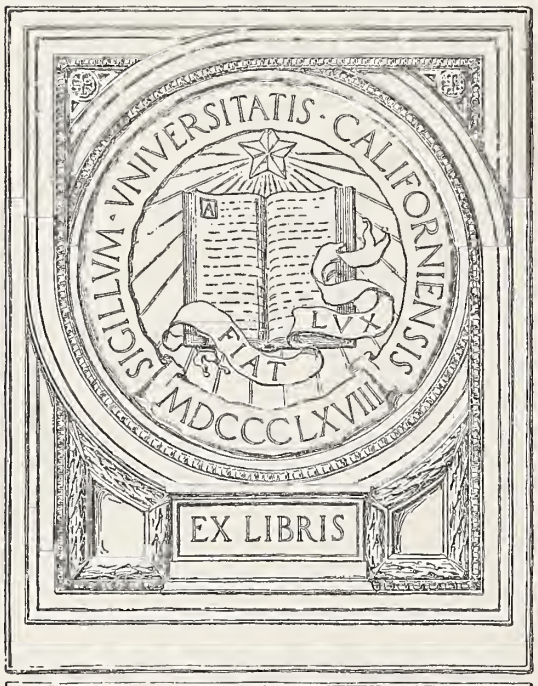

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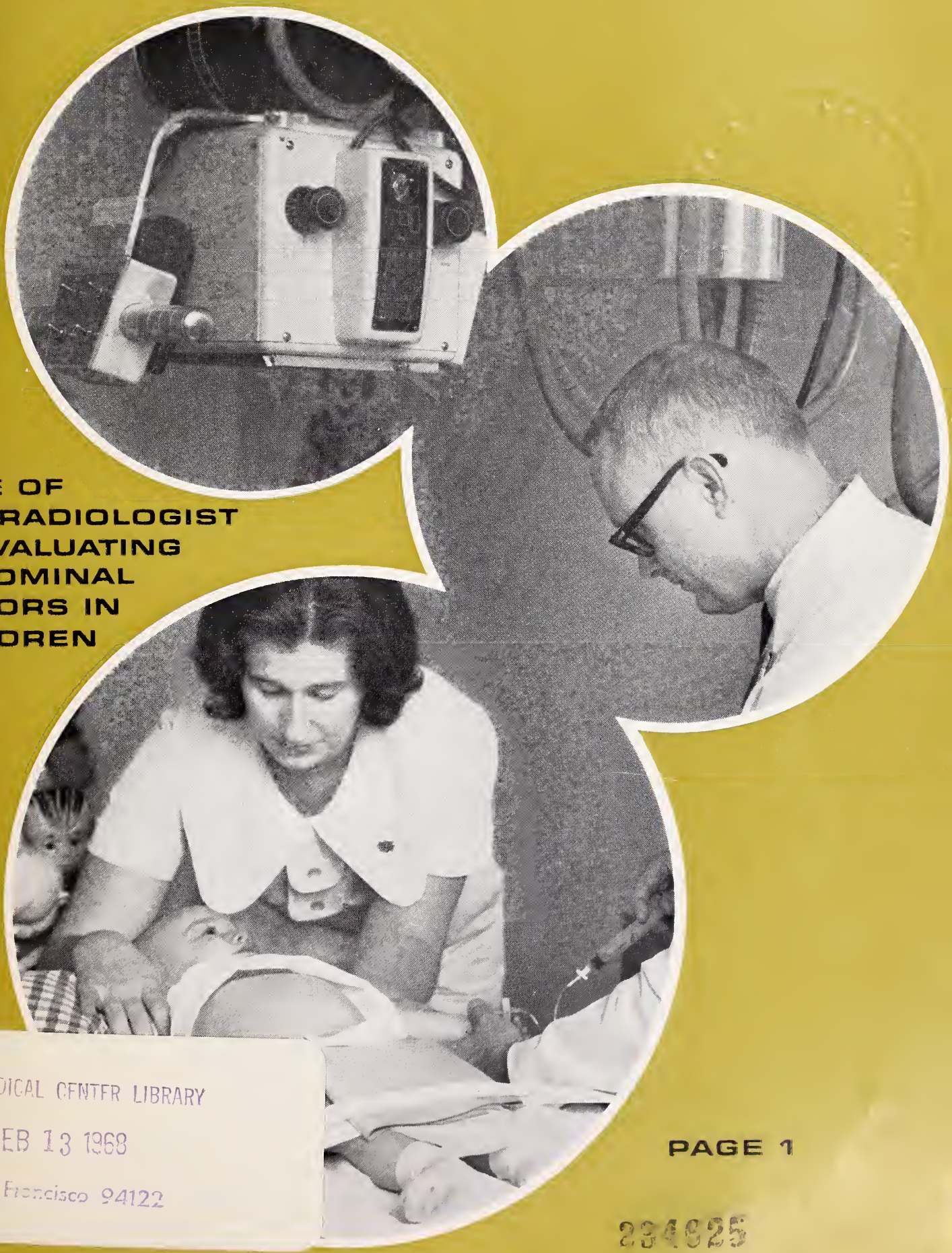

THE ROLE OF THE RADIOLOGIST IN EVALUATING ABDOMINAL TUMORS IN CHILDREN

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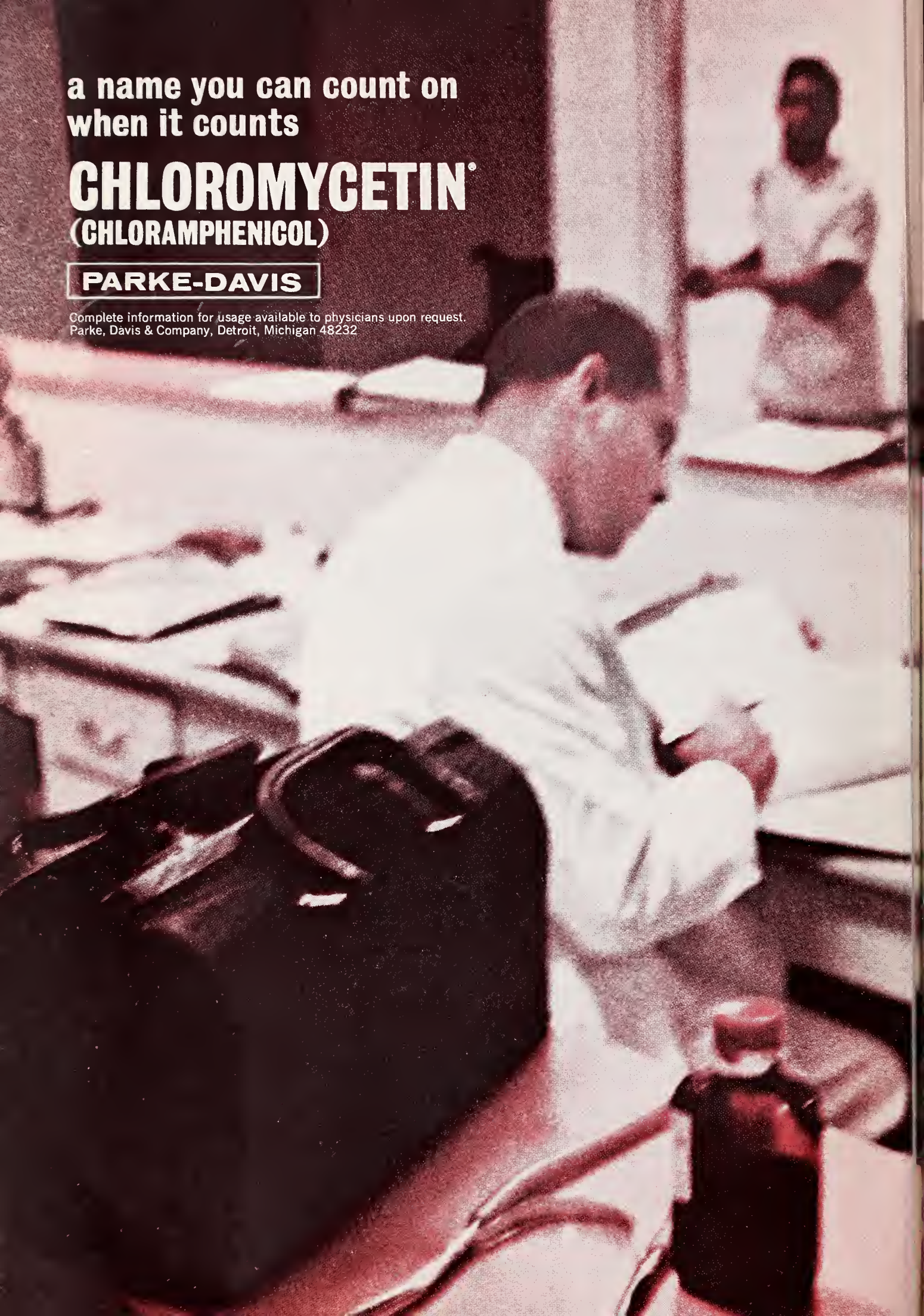

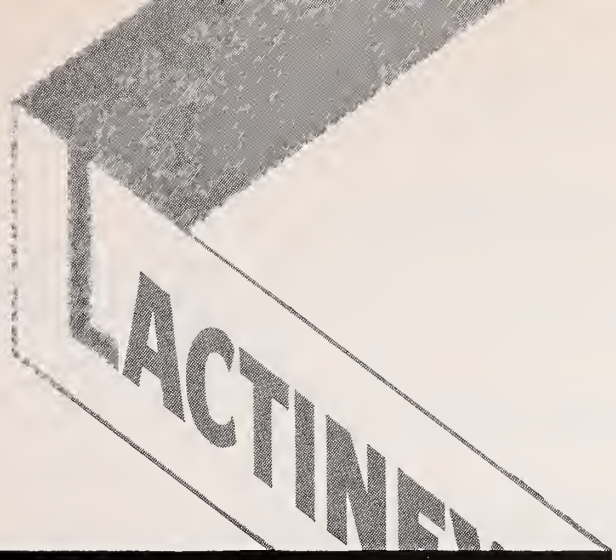

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JOURNAL OF THE MEDICAL ASSOCIATION Georgia

The Role of the Radiologist in Evaluating Abdominal Tumors in Children

DAVID H. BAKER, M.D., *and* WALTER E. BERDON, M.D., *New York City*

A correct diagnosis is possible in most cases by combining all known clinical features with a proper radiographic approach and interpretation.

To approach a roentgen discussion of abdominal tumors in infants and children, the stage must be set. Many clinical facts must be known by the radiologist. The age of the patient is critical, as abdominal masses in infants and children are very likely to be of completely different origin. Almost as important are the events surrounding the discovery of the mass. Was the mass discovered at birth? Was it found by a parent or during a routine examination in a well child? Was it discovered during an examination prompted by constitutional symptoms such as fever, abdominal or bone pain, or because of failure to thrive? All of these have a bearing, as will be discussed. Next, one must know the physical findings and the pertinent laboratory data. These findings should include the blood pressure, blood count and urinalysis, in addition to other findings.

Chest and Abdomen Films

Where does the examination proceed from this point? We realize that the age of the patient will largely determine what we find; however, the roentgen evaluation in both age groups proceeds along similar lines. Our initial examination would consist of a chest in frontal and lateral projection and of an abdomen in frontal and lateral projection, realizing that the abdomen films were merely serving as preliminary films to an intravenous pyelogram, which we would proceed to do immediately as the next step.

The plain films of the chest are examined seeking evidence of parenchymal disease, pleural reaction, mediastinal enlargement or evidence of metastatic bone involvement in the thoracic cage or shoulder girdles. The plain films of the abdomen are examined for masses as seen by displacement of small bowel loops or organs, and evidence of abdominal calcification. We prefer that the lateral abdomen film be done with the patient supine and the beam horizontal, as any displacement of abdominal or retroperitoneal structures detected would have to be the result of the mass and not the shifting of the structures with change in body position. By combining the clinical data, the proper radiologic examinations and their findings, our accuracy in diagnosis of abdominal masses approaches 100 per cent.[3]

The IVP done in our department is perhaps somewhat different than in others; all of our films are exposed prone, without the benefit of carbonated beverage. We feel this shifts the gas to the flanks and allows maximum visualization of the kidneys. This has not been so much help in the infant with vo-

From the Department of Radiology, Babies Hospital, Columbia Presbyterian Medical Center and Columbia College of Physicians and Surgeons, New York, N.Y.

luminous small bowel gas as it has been in older infants and children. We find that of value also to fill out both the renal pelvis and the ureters. Our usual dose is 3½ to 5 ccs. per kilogram of body weight. This is considerably in excess of the dosage usually recommended; however, it is now the standard procedure in all major pediatric x-ray departments. We have found it to be both safe and effective in visualizing renal function. The contrast material in our department is Hypaque 50 per cent and, as this is a sodium salt, we make certain that the infants in particular, but all children, are not dehydrated. A film is exposed immediately after injection to take advantage of the nephrogram phase. This is a combination of the vascular and renal tubular phase, and actually in the small infants is more of a bodygram[4] so that all tissues "light up" except those with deficient vascular supply, i.e., cysts and some tumors. In the older child the kidney becomes quite dense and non-functioning renal masses are quite evident. Following that initial film, films are exposed at 5 and 10 minutes. Most children have excreted the majority of contrast by then. At the time of these films, either the 5 or 10 minute film, a lateral is also taken again, preferably cross-table or horizontal beam, for the reasons stated.

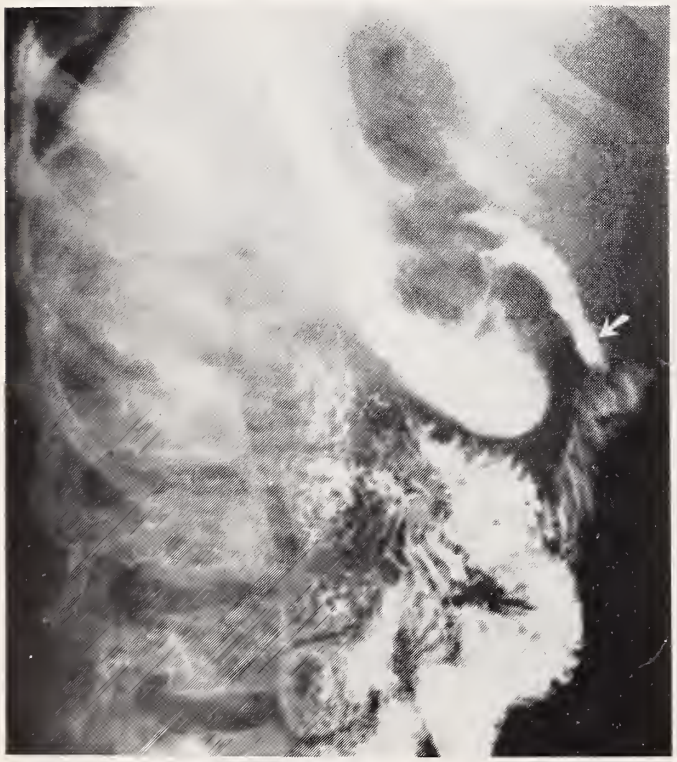

FIGURE 1

An 11-year-old girl with a right upper quadrant mass; the liver scan had been interpreted as hepatoma. Lateral gastrointestinal study shows anterior displacement of the retroperitoneal duodenum by a Wilms' tumor; the tumor had pushed normal liver up and the liver scan had been erroneously interpreted as the filling defect of a hepatoma.

The combination of the clinical data and the chest and intravenous pyelogram done as described is usually enough to allow the diagnosis. We have used other techniques as well, however. The next most likely study we would employ, if the above was not conclusive, would be the contrast study of the intestine. Nonflocculating barium is our choice for

FIGURE 2A

An infant with an abdominal mass showed on the intravenous pyelogram pelvic calcification, toothlike in shape and right hydronephrosis and hydroureter. Anterior-posterior films suggest a pelvic teratoma.

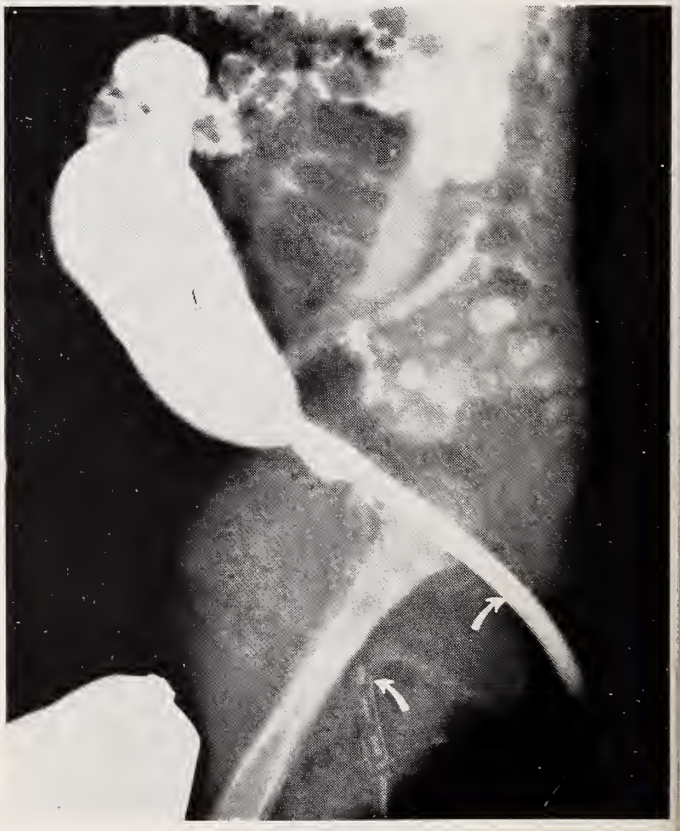

FIGURE 2B

A lateral film on the same patient, with a catheter in both the rectum and bladder, shows the calcifications to be behind the rectum, indicating retroperitoneal location of the teratoma.

gastrointestinal contrast media and we would use it to separate a retroperitoneal from a hepatic mass by the forward or downward displacement of the duodenum in a retroperitoneal tumor as opposed to posterior or inferior displacement of the duodenum by an hepatic mass. See Figure 1. We have also used the contrast studies to evaluate the presence of mesenteric or intestinal involvement by abdominal masses and also to judge rectal displacement in some pelvic tumors. See Figures 2A and 2B. As with the plain films and the pyelogram, the contrast studies of the intestine also include the use of lateral films.

We have tried occasionally, at the time of the intravenous pyelogram, to visualize the inferior vena cava. This is done by taking films during the injection of the contrast material into a leg vein. A number of techniques are available, but we will not go into the details of them as we feel the study has very limited value, particularly false interpretation of blockage of the cava by tumor mass. See Figure 3. This method should, by no means, be used to predict the operability of an abdominal mass in any given patient as there are spurious signs of inferior vena cava obstruction.[1] The patient may perform a valsalva maneuver, asleep or awake, and cause all of the contrast material to drain via the lumbar and azygos system. If one could see actual tumor masses within the lumen of the cava this might be helpful.

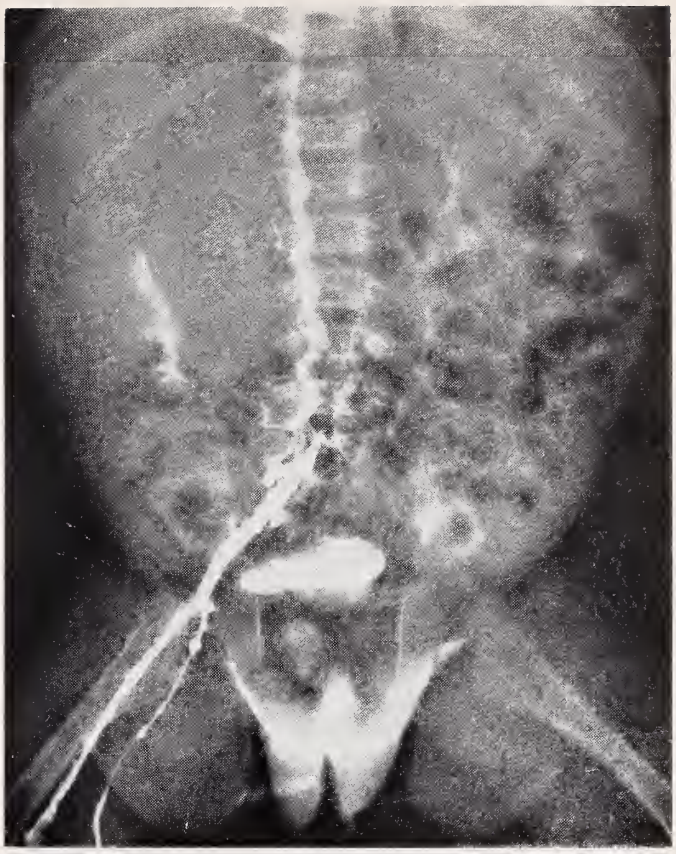

FIGURE 3

An infant with right neuroblastoma which was displacing the right kidney down and laterally. Inferior vena cavogram shows spurious obstruction with filling of the retroperitoneal collaterals. Tumor was resected totally and the I.V. cava was not obstructed.

Scanning Techniques

Scanning techniques have been developed which are occasionally helpful. This study, however, must be used in conjunction with other studies, as experience to date is not sufficient to allow unequivocal diagnosis on the basis of the scan alone. Many scans show a pattern of heterogeneity, making their interpretation difficult. On two occasions liver scans have suggested intrahepatic neoplasm when actually the liver was not involved and a retroperitoneal neuroblastoma or Wilms' was pushing the liver away. This shows that peripheral hepatic masses cannot be distinguished from displacement. Renal scanning might be of considerable use in evaluating those lesions which are associated with diminished blood flow to the kidneys, such as renal vein thrombosis. It also has been used to depict areas of non-functioning renal tissue, such as cysts. The procedure has the advantage of being extremely easy to perform and with further experience may well become an important tool in evaluating abdominal masses.

Arteriographic studies to detect the blood flow to a renal mass we have found to be less helpful than anticipated in our experience. The procedure is complicated by the small size of the vessels used for study necessitating a cutdown. There is a certain complication rate inherent, and also, the mass being investigated may well be an avascular tumor. Selective arteriography of the renal arteries is occasionally helpful to show an inferior adrenal artery originating from the renal artery and supplying a neuroblastoma, when the mid aortic injections grossly show a tumor but do not define its exact blood supply.

Common Pediatric Tumors

The principal tumors involving the abdomen in children are Wilms' and neuroblastoma. We know that the kidney with a Wilms' tumor commonly shows renal function, and therefore, collecting systems of the involved kidney will visualize and, because it is an intrarenal neoplasm, the collecting system will be distorted. See Figure 4A and 4B. These tumors may be located in either the upper or lower pole so that displacement may occur as well, but distortion of the collecting system is the hallmark of Wilms' tumor. We know also that Wilms' tumor very rarely involves the newborn; it is a disease of young children who are healthy and the mass is commonly an incidental finding. Wilms' tumor metastasizes to the lung and pleura and not to bone. We do not therefore, take long bone films on patients with Wilms' tumor whose chest film is normal, as we have not seen Wilms' metastasize to the bone with a normal chest. Wilms'

FIGURE 4A

A lower pole Wilms' tumor with functioning, though distorted, upper and middle pole calyces. A Wilms' tumor rarely shows non-function.

FIGURE 4B

An intrarenal Wilms' tumor demonstrates the marked distortion of all the calyces slightly reminiscent of polycystic change.

tumor very rarely calcifies; it may occasionally be bilateral and resemble polycystic kidney disease radiographically.

The other common mass we see in children is the neuroblastoma. When this arises in the suprarenal area, it displaces the kidney, usually down and forward, and it frequently contains amorphous calcium. The age incidence of neuroblastoma parallels that of Wilms' tumor, except there are more reports of very young patients and also of older patients with neuroblastoma than with Wilms'. It is interesting that in the "congenital" neuroblastoma cases, the tumor seems to infiltrate the adjacent organs, more than displace them. The critical differentiation between Wilms' and neuroblastoma is the presence of displacement of the entire kidney without distortion of the collecting system, plus the presence of amorphous calcium (Figure 5) within the mass. These children generally are sick and look sick. Pleural and pulmonary metastases are late occurrences while bony metastases are common early. Here we would always do a skeletal survey as part of the early evaluation. Neuroblastoma may arise in the pelvis and sympathetic ganglion, so that the mass need not be suprarenal in origin. However, the amorphous calcification is very frequently present regardless of the site of origin and serves as a good clue. Other clues

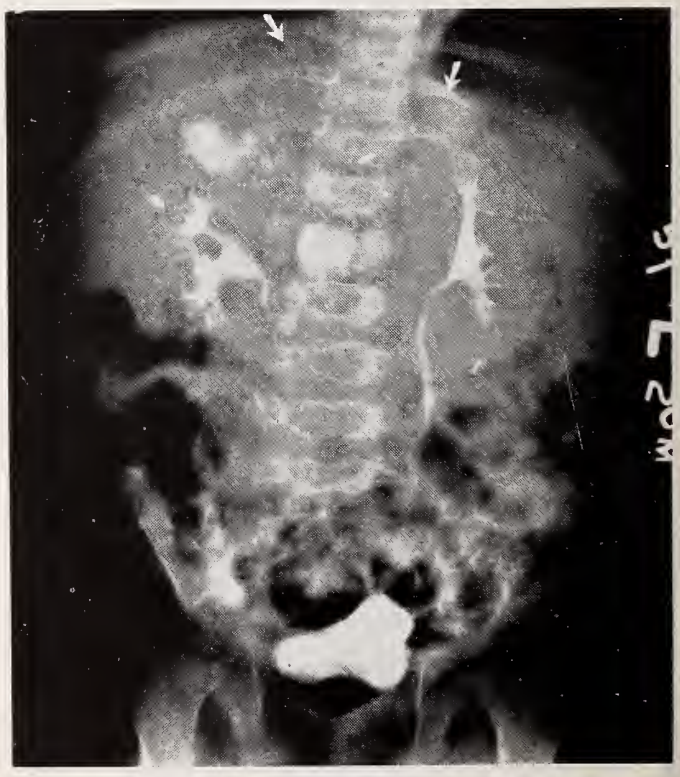

FIGURE 5

Neuroblastoma (seen following exploratory laparotomy) shows typical displacement of the kidney down and laterally with amorphous calcifications in the primary tumor and para-aortic ganglion. Though surgically unresectable, patient is alive and free of disease three years later, following radiation therapy and chemotherapy.

may be obtained by examining the urine for such metabolic constituents as the breakdown products of norepinephrine.

Tumors in the Abdomen and Pelvis

Tumors which arise in the abdomen and pelvis, while rare, deserve inclusion in this discussion. One such group of tumors are the teratomas. These may be presacral, pelvic or abdominal. They may present at birth or may not be discovered until later in childhood. The presence of calcification, sometimes in recognizable form such as a tooth or skeletal part, may be helpful in distinguishing these, as well as the presence of a considerable amount of fat. We have also had the opportunity of seeing patients with unusual malignant mesonephric rest tumors, one of which was an extensively calcified intrarenal and extrarenal lesion. See Figure 6. This, in our experience, would be extremely unusual for Wilms' tumor. A suspected Wilms' tumor in the newborn is much more likely to be mesodermal rather than epithelial in origin and, as previously stated, renal tumors usually function. We have seen such a patient who was born prematurely weighing 1200 grams. A mass was easily palpable and felt to be of different consistency by different observers and to transilluminate by some. The IVP showed slight function of dilated distorted calyces after the original films showed a negative nephrogram. At operation a large solid intrarenal tumor was found which was a benign leiomyoma. See Figure 7. The fact that the kidney functioned and showed a distorted collecting system should have suggested a solid tumor rather than the more common cause of renal masses in the newborn due to obstruction.

Displaced Kidney

As noted, tumors not of renal origin may displace the kidney. Such was the case in a two-week-old male referred to us with the chief complaint of an inguinal hernia who was demonstrated to have a large abdominal mass, and an accompanying IVP showed a large mass on the left, pushing the kidney out and displacing the ureter anteriorly and to the right. The bladder was being displaced to the right as well. The unusual aspect of this case was that the intraperitoneal portion of the bladder was also displaced. This would be an extremely rare finding for a mass originating in the kidney. In addition, the collecting system was being pushed, without distortion. These two features made us feel that this was probably not a Wilms' tumor but rather a retroperitoneal tumor arising near the base of the bladder and extending upward. Negative nephrogram on the IVP supported the presumption of a cyst. See Figure 8. During the early phase of the study definite septae were felt to be present within the mass, further suggesting a cyst. At operation a large retroperitoneal

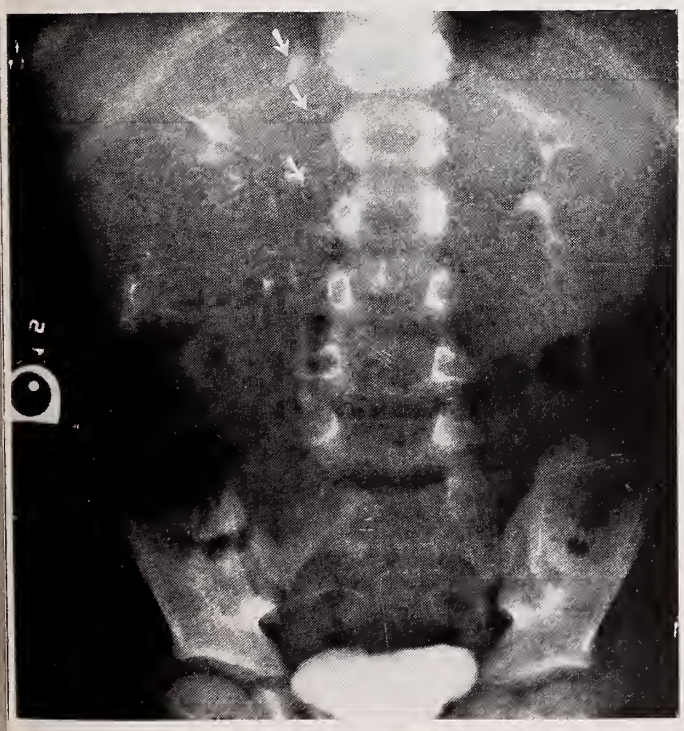

FIGURE 6

A rare malignant mesonephric tumor (not Wilms' tumor) showing calcification (similar to neuroblastoma) but with obvious distortion of the calyces from intrarenal tumor (as in Wilms'): patient died without response to any form of therapy.

FIGURE 7

A 122 gram premature infant with faint function and distortion in right renal tumor. A leiomyoma of the kidney was found at surgery. The mass had appeared to transilluminate during clinical evaluation.

lymphangioma, arising from the bladder and extending upward, was removed.

The last two examples cited above illustrate the importance of using all of the information available, both clinical and radiographic, to arrive at the correct diagnosis.

Differential Diagnosis

Abdominal "tumors" in the newborn may not be tumors at all. Obstructed renal duplications may occasionally distort the collecting system and therefore resemble slightly Wilms' tumor. Wilms' tumor is very rare at birth, despite its presumed congenital origin, so that a large renal mass seen on the plain film of a newborn, which does not function, is unlikely to be a Wilms' tumor. The intravenous pyelogram would resolve the problem, as masses which do not function in the newborn are likely to be multicystic kidneys, which are usually called unilateral multicystic kidneys. However, in our experience, the other kidney is frequently abnormal to some degree, commonly demonstrating the ureteropelvic junction obstruction. If a newborn with a large mass shows no function on early films, delayed films up to 24 hours may be necessary, as severely damaged kidneys from hydronephrosis, either due to reflux or ureteropelvic junction obstruction, may function very slowly indeed.

With less destruction, a "rim sign" may be seen, indicating a small amount of residual parenchyma functioning; or the renal papillae may be distorted 90 degrees to their usual orientation and appear as "crescents" outlining the nonfilled, dilated calyces. If the mass transilluminates and feels soft, one may occasionally directly needle such mass and inject contrast material which shows an enormous sac (Figure 9) resulting from ureteral pelvic junction obstruction.

Renal Vein Thrombosis

We have seen a two-week-old child with renal vein thrombosis who, following an episode of diarrhea, developed hematuria and was discovered to have a large right sided mass, not previously present. Occasionally, but very rarely, Wilms' tumor presents in such a fashion. The IVP showed a negative nephrogram corresponding to the mass. (See Figures 10A and 10B.) For some reason a retrograde was done. It is very uncommon in our hospital, as the pyelogram in most instances gives sufficient information so that the retrograde is not needed. An elongated spidery collecting system was demonstrated and at operation this mass grossly resembled a Wilms' tumor. Histologically, the diagnosis of renal vein thrombosis was established. The third factor, in addition to the mass and the hematuria, was hypertension. While both hematuria and hypertension are very rarely present in Wilms' tumor, they are typical of renal vein thrombosis. In addition, this child was two weeks of age, which would have been most unusual for a Wilms' tumor, particularly in considering that the occurrence of hematuria or hypertension in Wilms' tumor is usually a very late manifestation.

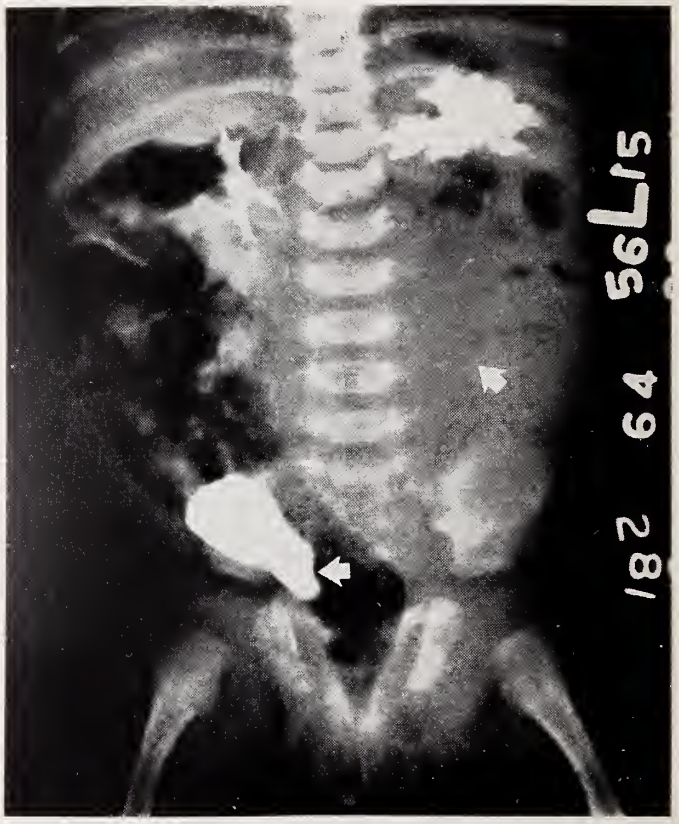

FIGURE 8

One-month-old infant with soft mass thought to be Wilms' tumor. Intravenous pyelogram shows trigonal part of bladder (intraperitoneal) to be involved, and mass to be lucent with definite septae (see arrows) and displacement of the left kidney. Preoperative x-ray diagnosis of cystic mass confirmed at surgery when a resectable lymphangioma of retroperitoneum was found.

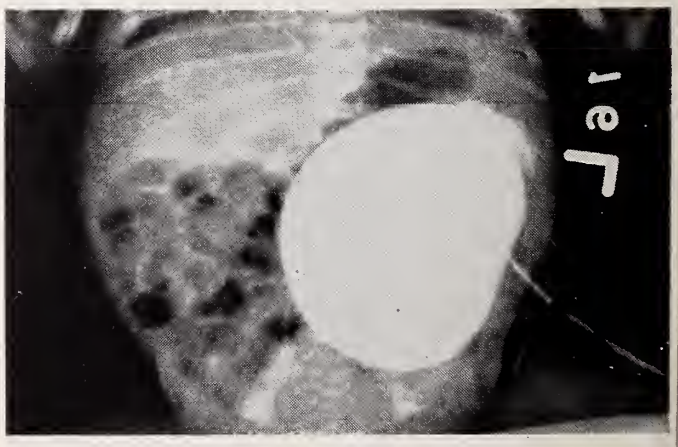

FIGURE 9

Nonfunctioning left flank mass in newborn infant was aspirated and the aspirate replaced with contrast agent: mass proved to be hydronephrotic left kidney secondary to ureteropelvic junction obstruction. Such hydronephrotic kidneys and multicystic kidneys in the newborn usually show no function (in contrast to Wilms' tumor).

In the newborn with a large suprarenal mass which contains calcium, adrenal hemorrhage would be a more likely diagnosis than neuroblastoma. Extensive adrenal hemorrhage in an older child, similar to that seen in the newborn, would be most unusual without the underlying abnormality of the adrenal gland, such as rupture of a pre-existing neuroblastoma.

Meconium peritonitis may present as scrotal tumor masses. We have had the experience in patients suspected of having testicular tumors of identifying calcium in the scrotum on the plain films. When this is done, a careful search for calcium in other areas of the abdomen, frequently over the liver, is made, as we have seen several patients who had meconium peritonitis in utero and, as the scrotum is in contact with the abdominal cavity at this stage, meconium had free access to the scrotum once it was outside the intestinal lumen.[2] Reaction to in utero perforation is scarring and calcification; this may occur in the scrotum as well as in other parts of the abdomen. Some such patients have been demonstrated to have cystic fibrosis and all patients with scrotal calcification should have a Sweat Test performed. The majority of these patients have not had clinical signs of obstruction at birth and the perforation of the intestinal tract has sealed, so that gastrointestinal studies done after the discovery of such meconium peritonitis have been normal.

FIGURE 10A

A two-week-old infant with hematuria, hypertension, and an enlarging right flank mass showed no function but a lucent renal area on the intravenous pyelogram was seen.

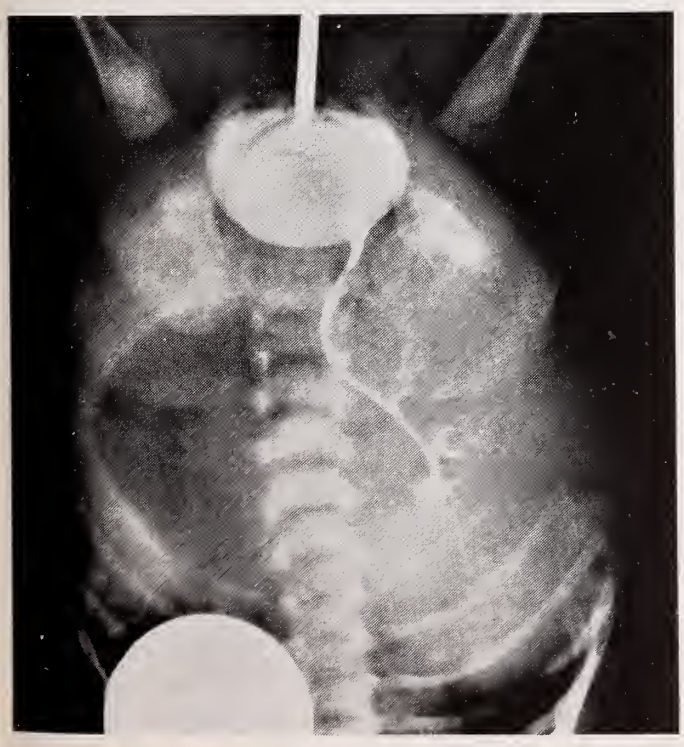

FIGURE 10B

Retrograde pyelogram shows distortion of the calyces with spider-like elongation similar to some polycystic kidneys. Diagnosis of engorged kidney without tumor but with infarct from renal vein thrombosis was confirmed at the time of nephrectomy.

Summary

By adhering to certain principles in evaluating abdominal masses in children, a correct diagnosis is possible in most. These principles include combining all known clinical features with a proper radiographic approach and interpretation. Films of the chest and abdomen are made at right angles as the initial step. A careful intravenous pyelogram, done as outlined above, combined with the plain films is most likely to reveal the correct diagnosis and should be done as the initial investigation. Criteria for determining renal, suprarenal, retroperitoneal, abdominal and pelvic masses, benign and malignant, are stated. The use of adjunctant methods such as positive and negative contrast studies of the intestines, scanning techniques and the evaluation of both venous and arterial blood supply to the masses have occasionally been added to the above. The simple procedure has been most reliable for us.

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Progress in Burn Management

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THE TOO FREQUENT STATEMENT, "despite new methods of treatment there is no reduction in mortality in burn patients," is an *absurdity*.

Reports from burn centers and other facilities where effective burn treatment is carried out very definitely demonstrate a significant decrease in mortality as well as a reduction in morbidity and a shortened hospital stay for the burned patient. In addition to new methods of treatment, there is an increasing number of physicians with an intense interest in the care of the burn patient. As in any other phase of medical practice, appreciation and concerted effort do a great deal in improving care.

Customary sources of information regarding burn therapy have been enhanced by an annual one-and-a-half day National Burn seminar, which recently held its eighth meeting. Increasing from an attendance of 12 physcians at its first meeting to some 150 physicians plus 250 others (scientists, nurses, physiotherapists, technicians, etc.) at its 1967 meeting, the seminar has been a stimulus for the development of the American Burn Association. This organization will hold its first meeting in the spring of 1969. Like the seminar, it will not only be a medium for free exchange of information regarding new developments, research, etc., but it will also prove to be a fine educational effort for those who come to grips with the problem on a day-to-day basis.

Fluid Therapy

No satisfactory resolution of the fluid vs. fluid plus colloid argument has resulted. Definitely though, in practice, as well as in theory, there has been a major shift to the use of intravenous crystalline fluids alone in the "shock" phase.

From the Departments of Surgery and Medical Education, St. Joseph's Infirmary, 265 Ivy St., Atlanta, Georgia 30303.

For most, the fluid of choice is Ringer's Lactate, and the best and easiest formula for administration has been developed by Baxter[1] who administers Ringer's Lactate at the rate of 4 ccs/% surface area burn/kg during the first 24 hours. His reasons for using Ringer's Lactate are well documented and his method is supported by extensive study which reveals the pH and the CO_2 are held at good levels with this treatment. He recommends monitoring venous pressure during resuscitation and points out that urinary output is usually about 70 ccs/hour. With this regimen there is less nausea, less ileus in the post-shock phase. Usually one-half of the total fluid requirement is given during the first 8 hours, one-fourth during the second 8 hours and one-fourth during the third eight-hour period. During the second 24 hours, he gives 2 to 3 liters of water (not Ringer's Lactate) and by the third day, usually oral fluids.

Baxter points out that the freshly burned patient (first 12-24 hours) is unable to retain colloid.

Topical Therapy

Probably the greatest impetus to the control of burn wound sepsis in the past 4-5 years has been the advent of new methods of topical therapy. Four major technics are of value: 1) Silver nitrate, 0.5% solution; 2) Sulfamylon Acetate®; 3) Gentamycin; and 4) Silver sulfadiazine.

Unfortunately for the majority of practicing physicians, 2 and 3 listed above are still under clinical investigation and are not yet available for general use. The fourth is still in initial control studies by its originator.[2]

The details of use of silver nitrate, Sulfamylon® and Gentamycin are extensive and documented in the literature, and too detailed to present here. Silver

sulfadiazine has proven to be of benefit as demonstrated in a recent presentation[3] and in an exhibit at the Congress of the American College of Surgeons in Chicago (1967).

Silver nitrate can be used effectively by anyone, prepared locally by a hospital pharmacist, but, certain electrolyte changes have to be carefully monitored. For hospital personnel, it has been objectionable because of staining of clothing and equipment. The other topical agents have been a boon to nursing procedures because of ease of applicability and less complicated side effects.

The most striking improvement in topical burn care has been achieved with the combined use of Sulfamylon® and homografts.[4] The repeated use of homografts as a dressing markedly reduces burn wound sepsis. In addition, in evaluating wound cohesiveness with repeated changes, it results in more accurate appraisal of proper timing for autograft application as to when it will adhere more quickly and permanently. Personal experience with Sulfamylon Acetate® has been most satisfactory.

Antibiotics

Varied preferences occur as to type, initiation of therapy and vigor of dosage of antibiotics. Most burn therapists are in agreement that early treatment of the fresh burn should be directed toward H. Staph. aureus and B. hemolytic Strep., the common inhabitants of skin most apt to cause *early* sepsis. In the absence of contraindications, pencillin is the drug of choice. One physician routinely uses one million units of aqueous penicillin in the first bottle of intravenous fluids as burn shock therapy is begun. Erythrocin® can easily be substituted in treating patients with known penicillin sensitivity.

Again, we have to draw on known standards and facts to avoid mistreatment. As in other infectious diseases, specific treatment should be directed against the offending organism (as proven by wound cultures from multiple sites and if needed, cultures from blood, urine and feces), or if sepsis is present and cultures are not available, the anticipated offending organism(s). The use of broad-spectrum antibiotics, as such, is to be avoided for the following reasons: 1) Known catabolic effect; 2) More prone to allow rapid overgrowth of Candida albicans; and 3) Less specificity.

When sepsis exists, or the burn wound sepsis is so great that septicemia is apt to occur, again various drugs are preferred for a variety of reasons: 1) Sodium oxacellin has been used for "steady cover"; 2) Polymixin B, Colistin, Kanamycin, a choice for gram-negative sepsis; 3) Gentamycin (where available) for Pseudomonas and H. Staph. aureus; 4) Sodium cephalothin for Klebsiella-Aerobacter groups; 5) Chloramphenicol is still widely used and is effective for both H. Staph. aureus and gram-negative organisms.

Most frequently, a combination of antibacterial agents is preferred and *necessary* when sepsis presents. The advantages, disadvantages, etc. of each antibiotic are a matter of record to those who plan to use them.

Skin Grafting

Other than the discussion of the influence of homografts (see Topical Therapy), the enthusiasm for the mesh graft technic has increased tremendously and is a feature of importance. The technic is well described[5] in the original presentation and in subsequent reports. Recent personal experience, as well as those of MacMillan et al,[6] in reconstructive technics (antecubital, popliteal fossa contractures, etc.) have enlarged the scope of the mesh graft method.

A new trial modification of the expanded mesh technic will expand the surface area of the donor skin from 3:1 to as high as 12:1 ratio.[7] This latter technic, based on the same principle but using a different mesh dermatome, is now under investigation in two centers and in patients, so far, has shown promise of significance.

However, attention must be paid to details of every plastic and reconstructive operative technic, both old and new, to produce a satisfactory end result in rehabilitation of the burned patient.

Splints, Pins and Traction

Never let it be said that suitable orthopedic consultation and mechanical devices can't help.

It has been ably demonstrated by physicians at the Galveston Shriners' Burn Center that pins and skeletal traction can be used with minimal morbidity in correcting disability and supporting burned extremities. A little special attention to the type of pin and care of the pin wound during its use make morbidity from this device almost negligible.

It is amazing what a splint and bracemaker can do in assisting in the improvement of the burn patient during all phases of repair.

Electrical Burns

Burns caused by electrical current cause the burn specialist to regroup his thinking regarding a therapeutic approach. He is faced, as are those in the immediate proximity of the injury, with a different entity in many respects.

Low voltage contacts are more apt to produce cardiac arrest requiring immediate cardiac and respiratory resuscitative efforts. Any voltage, but especially the higher voltages, produces transient myocardial damage (in survivors) and may produce

renal changes also. Higher voltages are apt to produce, in addition to a dessicating type of burn wound, the conventional changes one expects in thermal burns because most individuals burned by electricity are wearing clothing which catches fire.

High voltage current producing a burn necessitates wounds of exit, as well as entrance. Therefore, care must be taken in examining the patient. Due to the surge of current, muscle group contractions may occur with such force that fractures will result. Over and above this, the shock may throw an individual off a power pole, against a wall, etc., producing associated and unexpected trauma.

The high voltage type burn wound itself is almost immediately sterilized; dissolution, slough and bacterial invasion, therefore, occur late—much later than in thermal burns. The wound is deeper; its superficial portions are deceptive in appearance because current is conducted to varying degrees and extent depending on the conductivity of the underlying structures. This is particularly true of skeletal muscle where massive destruction occurs under perfectly normal-appearing skin.

Certain features are of importance:

Burn shock from electrical current is totally different. Attention must be paid to cardiogenic effects and renal changes. Fluid administration should be directed toward alkalinization, reduction of a falling pH and maintenance of CO_2 at 22 mEq or better. If myoglobinuria presents, then remedial treatment should be instituted. In the electrical burn, more than elsewhere, the protection of keeping a near normal hematocrit is most advisable and may be the most important guide to fluid requirement (along with pH and CO_2).

Some authorities believe in early excision, likening the wound to a "crush injury." Others state that sepsis is the chief indication for excision. Again, more so than in thermal injury, sepsis is slow to appear and is always indicated by an increase in temperature and pulse rate. Perhaps the most common approach to local wound management is that of conservative and repeated debridement, taking at one time only the tissue obviously necrosed and in this way preserving as much viable tissue as possible.

Problems and Contemporary Peculiarities

Pulmonary: With the advent of improved topical and systemic antibiotic therapy in control of wound sepsis, death is occurring more frequently from pulmonary sepsis, usually due to invasion of Pseudomonas or Klebsiella-Aerobacter organisms. This is aggravated by the use of pulmonary ventilatory technics since this equipment is so easily contaminated and so difficult to keep sterile.

Tracheostomy should be avoided at all costs because of its contribution to the problem stated above. A burn of the head and neck alone is *not* an idication for tracheostomy. Its use should be limited to only otherwise uncontrollable respiratory distress.

Aerobacter: With refinements in therapy, this organism appears to be emerging as an agent of prominence in burn wound sepsis; again, the result of newer antibiotics and topical therapy being more effective in avoiding sepsis due to Pseudomonas.

Candida albicans: Overwhelming candidiasis is producing problems in rehabilitation of the burn victim. Deaths as a result of blood stream and organ invasion by C. albicans have been reported. The effect of Candida may be overwhelming; sometimes very rapid, as well as devastating, and investigators suggest use of wound culture technics for yeast and fungi, as well as bacteria. It is interesting that they have shown that its (candidiasis) earliest indicator may be a positive growth in the urine.[8] Also, infected venous cutdown sites may be an early source for the entrance of Candida into the patient.

Curling's Ulcer: Frequently an asymptomatic entity ordinarily reported to occur in an incidence of 1.6 to 2.0 per cent more recently is reported as occurring in about 12 per cent of thermal burns. A variety of methods of treatment are described, for the most part conservative because the extent of so many burn wounds mitigates against corrective surgery. Many therapists insist that the burned patient receive antacids and a bland diet as soon as possible once oral intake is begun.

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Early recognition of extracranial arterial obstructions is of great importance in effective surgical management.

Experience With the Surgical Treatment of Strokes

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THE FIRST PAPER [1] presented before this association on the surgical treatment of strokes was given by the author in May 1960. In 1954, Eastcott, Pickering and Rob[2] reported the first successful carotid endarterectomy for the management of cerebral vascular insufficiency. Since that time many reports[3, 4, 5] have been published attesting to the value of relieving obstructions in the cervical and thoracic segments of the cerebral circulation. With the passage of time, experience has been gained in the surgical management of extracranial arterial obstructions and certain features of cerebral vascular insufficiency have become apparent. Although many questions have been answered, certain problems remain unsolved—particularly in regard to the treatment of patients with neurological deficits. Opinions, also, vary as to the size of surgically significant obstructing plaques. Due to the variability of the natural history of patients with strokes, evaluation of the results achieved by surgery has been extremely difficult. This report concerns some of our experiences with the treatment of cerebral vascular insufficiency during the past 12 years.

Pathology

For all practical purposes most obstructions in the cerebral circulation are due to atherosclerosis. Even though we recognize atherosclerosis as a generalized disease, it usually manifests itself as a severe, localized, segmental involvement of the bifurcation, divisions or branching of a vital artery. In considering cerebral vascular insufficiency, *proximal* (thoracic or arch obstructions) are recognized along with *cervical* and *intracranial obstructions*. Multiple lesions are frequent and the obstruction may be complete or incomplete. Stenotic and completely obstructing lesions at the thoracic level are always segmental in nature and amenable to surgical correction. Completely obstructing lesions in the cervical segments, usually at the origins of the internal carotid and vertebral arteries, are under special circumstances susceptible to surgery. Most stenotic lesions in the cervical area are amenable to surgical correction although in rare instances the atheromatous process may extend so far distally that an acceptable correction cannot be achieved. At the present time intracranial obstructions are not being treated surgically, although some successful operations have been reported.

Clinical Manifestations

Neurological symptoms vary with the location of the obstructive process. Cervical obstruction in the carotid system leads to ipsilateral, monocular visual disturbances and contralateral sensory and motor defects. Dizziness, giddiness, black-out spells and loss of mental acuity are frequently encountered in patients with carotid artery insufficiency. Symptoms associated with vertebral-basilar insufficiency are usually bilateral in nature. These patients may have

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bilateral motor and sensory disturbances, loss of function of cranial nerves—three through eleven—along with vertigo, ataxia and bilateral visual abnormalities. Deficits frequently skip from one side to the other.

Obstructions of the major vessels proximally at the aortic arch level have symptoms of carotid artery insufficiency if the obstructive process interferes with blood flow in the carotid arteries. In addition, functional or absolute ischemic symptoms in the arm may occur when the subclavian vessels are involved. One must keep in mind that intracranial arterial obstructions along with intracranial expanding lesions may produce clinical features similar and indistinguishable from those produced by extracranial brachiocephalic obstructions.

The physical findings in patients with cerebral vascular insufficiency will depend upon the neurologic deficit produced. Specific vascular findings are frequently helpful in determining the site of obstruction. Blood pressure, pulse and oscillometric determinations will be reduced or absent distal to the obstructive process. Murmurs, which may be systolic or continuous, are frequently heard over sites that are stenosed or incompletely occluded. Why some stenotic lesions produce loud and easily heard murmurs and others do not is not completely understood. One does not expect to hear a bruit over a completely occluded vessel. Ophthalmodynamometric studies are helpful if positive, but this study is of little value when the determination is normal. It has been estimated that 35 per cent of patients with significant extracranial vascular obstruction have no localizing vascular signs.

Subclavian Steal Syndrome

In 1961 Reivich et al[5] first presented and described a new syndrome—the subclavian steal syndrome. Many authors have subsequently confirmed their original observations and experimental studies. The clinical features of this syndrome are due to obstruction of the subclavian artery or the innominate artery proximal to the origin of the vertebral arteries. Due to a reversal of blood flow from the basilar systems into the low pressure subclavian artery via the vertebral artery, symptoms of basilar-vertebral insufficiency occur along with functional ischemic symptoms in the involved extremity. Most reported cases have been caused by atherosclerotic obstructions; however, the syndrome may occur following a Blalock-Taussig shunt, following use of the subclavian artery as a by-pass for aortic coarctation, following ligation of the subclavian artery after use of this vessel for cardiopulmonary by-pass. Rarely embolic occlusion or congenital atresia and stenosis of the subclavian artery may lead to the subclavian steal syndrome.

Diagnosis

As is true with most diseases, a carefully taken history and a complete physical examination is most important in establishing a diagnosis of cerebral vascular insufficiency. In certain instances a brain scan and an EEG will be helpful. Most physicians now feel that in order to properly evaluate patients suspected of having cerebral vascular insufficiency, routine arteriograms must be performed. This recommendation is based on the fact that properly performed arteriographic studies carry a minimal risk, and at the present time, we have no other method of determining the exact site and extent of the obstructing lesions.

Many differences of opinion are currently being expressed as to the best method of performing arteriography. Some vascular surgeons feel that aortic arch angiography should always be performed. Unfortunately, when one reviews arteriographic films, it is frequently noted that adequate visualization of the intracranial vessels has not been achieved. The surgeons at Baylor[4] favor routine four vessel angiography. The routine use of bilateral carotid arteriograms with one single oblique view as frequently performed is condemned. This type of study is inadequate in ruling in or out the presence of an intracranial expanding lesion such as a brain tumor or a subdural hematoma.

Location of Vessel Obstruction

From a practical standpoint, one can usually determine by physical examination whether vessel obstruction is located at the proximal or aortic arch level. Careful clinical evaluation will, also, usually indicate whether the obstruction is in the carotid or vertebral-basilar systems. If after evaluation we feel that the obstruction is in the carotid system, percutaneous carotid arteriograms are performed. When carotid arteriograms are performed it is felt that a minimally adequate study should include three views of the neck and skull on each side—Towne's view, oblique and lateral views. This type of study will provide adequate information on the status of the intra and extracranial vessels and allow one to detect shifts associated with expanding lesions. Obstructing lesions may be overlooked if only one view is taken as the atherosclerotic accumulation may be on the arterial wall parallel to the x-ray beam.

When obstructions are suspected in the vertebral-basilar system, the use of an aortic arch arteriogram performed by the retrograde Seldinger technique is helpful. Multiple films are taken using the Sanchez-Perez seriograph. This technique is also used in patients suspected of having the vertebral steal syn-

drome. In our hands, direct surgery upon the vertebral arteries has not been impressive. For this reason, along with the fact that most obstructions in the vertebral-basilar systems are in the basilar artery itself[6] we do not feel that routine visualizations of the vertebral arteries are indicated in a patient suspected of having carotid artery insufficiency. In addition, correction of obstructions in the carotid system will frequently produce enough increase in total cerebral flow to relieve symptoms that may be due to vertebral-basilar insufficiency. Aortic arch arteriograms are essential in evaluating patients suspected of having proximal obstruction at the aortic arch level.

Ideally one would like to be able to inject contrast media intravenously and have serial biplane views of all the arteries from the aortic arch to their intracranial termination. Hopefully this technique will be available in the near future.

Surgical Treatment

Patients with extracranial arterial obstructions frequently have other diseases that must be evaluated and treated before proceeding with arterial surgery. Hypertension, diabetes mellitus, cardiac and renal problems are often seen in this age group. After correlating the clinical and angiographic findings, patients are selected for surgery provided surgery is not contra-indicated due to other disabling problems.

All surgeons agree that the ideal candidate for surgery is the patient who is having transient cerebral ischemic attacks and who has marked isolated stenosis of the proximal portion of the internal carotid artery. These patients do not have neurological deficits and surgery is highly successful in preventing recurrent attacks and progression to frank or lethal stroke. Crawford et al[4] feel that all stenotic lesions producing a 30 per cent or more reduction in internal luminal diameter, as estimated from the arteriograms, are functionally significant and patients with such lesions are chosen for surgery. Others feel that the luminal diameter should be reduced by 50 per cent or more before recommending surgery.

Most surgeons have found that all obstructive lesions, whether partial or complete, in the great vessels at the aortic arch level are segmental in nature and these patients are candidates for surgery.

Patients with Neurologic Deficits

There is still disagreement regarding the best method of treating these patients. Completely obstructing lesions involving the base of the internal carotid artery are potentially correctable in approximately 50 per cent of cases. The surgeons at Baylor University[4] feel the chance of success in these patients is better if they are operated upon within 24 hours. Many patients with complete obstruction of the internal carotid artery have total hemiparalysis and aphasia if the dominant hemisphere is involved. Opening the internal carotid artery in these patients may lead to massive hemorrhage in the infarcted area[7] and worsening of the patient. We feel that these patients should be observed for three weeks before deciding whether or not to perform arteriograms and surgery. Treatment of patients with hemiplegia in the acute stage has been unsatisfactory.

Patients who have a progressive stroke should be studied by arteriograms as soon as possible. Frequently the base of the internal carotid artery will be found to be markedly narrowed and relief of the obstruction will bring about improvement.

Patients with partial paralysis or hemiparesis often have markedly stenotic lesions of the internal carotid artery which can be safely studied and repaired during the acute phase. When paralysis is partial or incomplete this indicates that infarction is minimal or absent and improvement may occur following restoration of blood flow indicating the reversibility of the cerebral lesion.

Operative Technique

Obstructive lesions of the large vessels arising from the aortic arch can be successfully treated in most cases by the by-pass principle. A sternal splitting or right third anterior intercostal incision is made and the ascending aorta is exposed. A knitted dacron graft is sutured end-to-side to the ascending aorta using a partial occlusion clamp. The graft, with various branches as needed, can then be anastomosed to the carotid or subclavian arteries in the cervical region. If possible, obstruction is corrected by performing a shunt between the carotid and subclavian arteries—e.g. obstruction of the left subclavian artery at the aortic arch level may be corrected by inserting a carotid-subclavian shunt.

The majority of patients with cerebral vascular insufficiency will be found to have obstruction of the base of the internal carotid artery. General anesthesia with 0.5 per cent Fluothane is presently being used. Dextran,[8] along with heparin is given to prevent operative and late thrombosis at the suture line. The blood pressure is maintained at normal or hypertensive levels. If necessary, an intravenous drip of Neosynephrine is given.

Surgeons differ on their indications for the need of an internal shunt and a patch graft. In the past we have used the Matas test (compression of the common carotid artery for 2 minutes) to determine if a shunt would or would not be needed. Unfortunately, there are some patients who appear not to need a shunt; however, following surgery a catastrophic result is evident. We are now using internal polyvinyl shunts and feel that better surgery can be performed

in an unhurried fashion without fear of damaging the cerebral cortex. In the past we have not used patch grafts frequently; however, as experience has beeen accumulated, we feel that patch graft angioplasty is important in assuring an adequate lumen and preventing thrombosis at the operative site.

With the exception of the subclavian steal syndrome, we have been disappointed with reconstructive procedures upon the vertebral arteries. If possible, total cerebral blood flow should be increased by surgery upon the carotid arteries. Frequently, relief of the obstruction in the carotid arteries will allow enough spill-over into the basilar system to correct vertebral-basilar insufficiency. In certain instances direct surgery upon the vertebral arteries may be helpful. In these instances a patch graft—with or without endarterectomy—is the procedure of choice.

Summary

Experience with the surgical management of strokes has been presented. Certain principles have become evident and standardized during the past 12 years. Many problems still exist, especially in treating patients with acute neurological deficits. It is hoped that the family physician will recognize the importance of diagnosing these patients before a frank stroke has occurred.

1938 Peachtree Rd., N.W.

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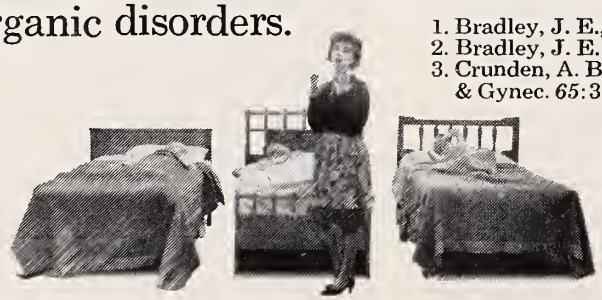

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What Does the State Board of Health Do Anyway?

CAVANAUGH MURPHY,* *Atlanta*

THE DOOR FROM THE HALL opens into a small, carpeted foyer. On the frosted glass window in the upper half of the door, words are lettered in gold. They say "Executive Offices"; and below, "Board Room."

It takes four steps to cross the foyer and enter the board room itself. An oblong conference table, finished in light walnut, almost fills the room. Three windows—flanked by tan drapes showing neat geometric designs in olive, brown and orange—look out on Atlanta's south skyline.

A glance through one of the windows shows the complex interchange of I 20, I 75 and I 85. Beyond, Atlanta Stadium rests impressively on its laurels, waiting for the Braves—and later the Falcons—to meet there and work out their respective problems.

Problems of a different sort will soon be worked out on the three-leaved table in the center of the board room. There are 18 chairs, upholstered in black/green leather, neatly arranged at the table. Yellow pencils, freshly sharpened, and clean white pads are laid out on the table before each chair.

It's 8:55, September 21

A large wall clock shows 8:55. It is September 21, 1967, the third Thursday in the month, and the State Board of Health is assembling for its monthly meeting. The site today is the building on Atlanta's Trinity Avenue that houses the main offices of the Georgia Department of Public Health.

The Georgia Health Code of 1964 (officially called Act No. 936, H.B. 162) says that the Health Department was created and established "to safeguard and promote the health of the people of this State."

How the Department goes about this "safeguarding and promoting" is the responsibility of the men entering the board room and settling into the green leather chairs. They are members of the State Board of Health, the men who set the policies that govern the Health Department. They approve or modify—and sometimes reject—Department programs, and decide how money appropriated by the General Assembly for health purposes shall be parcelled out.

The state's first Board of Health, created during the difficult reconstruction days of 1875, had $1,500 to work with during its first year of existence.

The ante has gone up. The brief cases and bulging folders that these men toss onto the polished table today contain papers spelling out item by item the health needs of Georgia for 1969.

Budget Is $164 Million

The proposed operating budget, that the Board members have poured over and will now settle down to pull apart, is considerably higher than $1,500. The total state-federal figure at the bottom of the page, requested for fiscal '69, says $164,139,477. The cost of good health is high in the mid-twentieth century.

The room is almost full; Health Department staff members and visitors occupy chairs side by side along the paneled walls of the room. Conversation flows free and easy as the Board members come into the room, singly and in pairs. Hands are shook and backs slapped as the new-comers enter. Except for specially called small meetings or extra-session gatherings of committees, the members of the Board seldom see each other from month to month. They

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live all over Georgia—from Dalton to Hahira, and it's a big state.

The Chairs Are Filled

Dr. P. K. Dixon, a Gainesville surgeon, and chairman of the Board since 1966 when Dr. "Pepper" Martin of Augusta retired after two years as chairman, tentatively fingers his gavel. Waiting for the conversation to subside, Dr. Dixon looks down the long table. If all of the 18 chairs are filled—meaning the Board is in full attendance, as it frequently is—he will be presiding over a group composed of 10 physicians, one from each Congressional district and nominated by the Medical Association of Georgia; two dentists, nominated by the Georgia Dental Association; two pharmacists, whose names were put forward by the Georgia Pharmaceutical Association; one veterinarian, whose nomination was submitted by the Georgia Veterinary Medical Association; one member nominated by the Georgia Municipal Association; one nominated by the Association County Commissioners of Georgia; and a member appointed from the state-at-large.

All were named to their posts by the governor of the state. A full term is for six years, although initial appointments to the newly constituted Board in 1964 were staggered by law from one year to the full six.

The hands of the clock have eased past 9:00 a.m. Dr. Dixon's gavel bangs, and the September meeting of the Georgia State Board of Health is called to order. Present are 15 members of the 18-man Board; the director of the Health Department, Dr. John Venable, is seated at the chairman's right hand. Attendance of members seldom dips below 15 or 16. The Board tackles a long and complicated agenda each month, and members have learned that to miss a monthly meeting is to fall badly behind in Board and Health Department affairs.

L.P.N.'s Representative Appears

As the meeting formally opens, the minutes of the August gathering are quickly approved and Dr. Dixon introduces Mrs. J. M. Stuart, chairman of the State Board of Licensed Practical Nurses. She is one of today's visitors, and one of a succession of health and health-related officials invited to appear before the Board for discussion on problems of mutual interest, or simply to sit in on the general session.

Representatives from M.A.G., from the Hospital Association, from the Georgia Association for Mental Health and the Georgia Pharmaceutical Association are among those who have appeared in the past in response to invitations from the Board.

Mrs. Stuart's appearance ties in with a long-running concern of the Board members over the

Board of Health members (seated, left to right) Dr. William Dickson, Dr. Lamar Peacock and Mr. Carl Pruett listen to staff report on air pollution.

personnel shortage in state-operated and private institutions. Following her informal presentation—punctuated by questions from individual members—Dr. Martin entered a formal motion, seconded by Dr. Earl McGhee of Dalton, to request Health Department action on the increased utilization of L.P.N.'s. The motion passed on a voice vote, and the Department officials were given additional support to approach the State Merit System to work out a stepped-up recruitment campaign for L.P.N.'s.

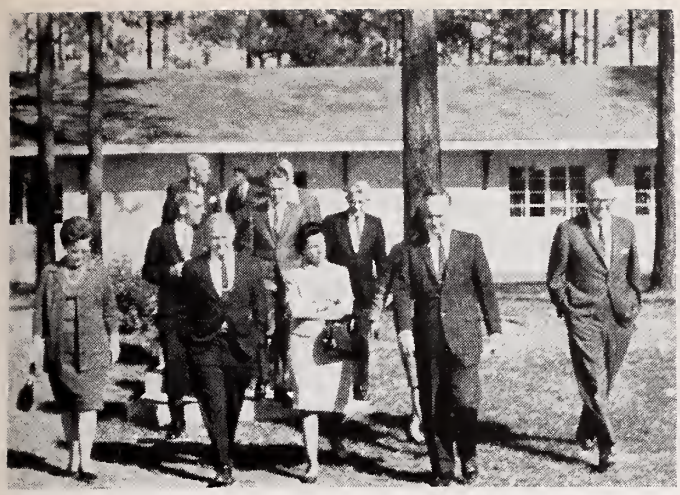
Water Pollution Comes Up

As Mrs. Stuart leaves, Ralph S. "Rock" Howard, executive secretary of the State Water Quality Control Board, comes quickly into the board room. Howard's unit is responsible for water pollution abatement, and while these activities no longer fall directly under the Board of Health's responsibility, they do inter-relate with several Health Department programs. The pollution control staff offices are in the Health Building, the "water boys" use the Department's lab under contract, and state health director Dr. John Venable is chairman of the Water Quality Control Board.

Howard's report is informal, free-swinging and specific as he cites progress and problems in pollution control since 1964 when his unit was created.

The Board of Health members are settling in now, obviously enjoying the report. Coats begin to come off and the tempo picks up. After careful questioning from Board members on major health-related pollution problems, Howard cites stream degradation by municipalities as his current number one problem.

He also comes in hard on suburban housing developers and their improper installation of "malfunctioning septic tanks." This is an area of health concern—usually encountered at the local level—and the Board members call for a report on standards for septic tank installation.



Board members, some of them accompanied by their wives, walk over the grounds of Southwestern State Hospital at Bainbridge with the superintendent, Dr. Manson B. Pettit.

The report will be compiled for study and possible official action by the Health Board.

Howard is just one of the "in-the-family" administrators who appear periodically before the Board to up-date the members on day by day operating progress. Past reports at previous meetings have included the areas of cardiovascular disease control, air pollution, tuberculosis control, epidemiology, operations of the Department's computers, crippled children's care and other areas of responsibility.

"Road Show" Meetings

At Board Chairman Dixon's request, the policy making group schedule some of their meetings away from Atlanta, usually at the site of a Department hospital. This "road show" technique gives the Board a chance for on-the-scene inspection of operations, improves levels of understanding by face-to-face discussion between Board members and health workers at all levels of responsibility, and cements good neighbor relations with communities deeply involved with Health Department activities at the local level.

Meetings have been held at Gracewood State School and Hospital in Augusta, at Rome where Battey State Hospital treats tuberculosis patients, in Gainesville and at other locations around the state. The Board's October meeting has already been scheduled for Central State Hospital in Milledgeville.

The group will convene in Thomasville on the third Thursday in November, as the Health Department now operates a dual rehabilitation unit for long term mental patients at Thomasville and Bainbridge. This will be the first chance the members have had to see the facility in operation.

Dr. Dixon's gavel keeps the meeting on reasonably close schedule. Dr. Venable, the Health Department director, reports monthly to the Board on activities and future programming at the executive level. At times this future projection, and Dr. Venable's requests for direction and response to members' questions, is quite lengthy.

25 Items and the Budget

However, today's meeting carries a crowded agenda—some 25 separate items—and the budget is still to be discussed. Dr. Venable compresses his report to a few key items, including the submission to the Board of a 175 page first draft of *A Comprehensive Plan for the Prevention and Control of Alcohol and Addiction in Georgia.*

The plan was drawn up by a specially appointed task force, following the Board's strong directive in March that such a study was badly needed. Dr. Venable stresses the tentative nature of the plan and requests that the Board members study it in detail and offer criticism—constructive or otherwise—at the October meeting.

From time to time during each monthly meeting, staff members or Department program directors move around the conference table passing out reports, fact sheets, proposed regulations, copies of key legislation—state and federal—administrative orders and other information documents to the members.

The brief cases and folders that bulged with papers at the opening of the meeting are beginning to spill over. The table is not so neat now; it is covered with paper; the scratch pads are covered with scribbled notes—figures, facts, quick thoughts pinned down for later consideration.

Reporters and Cameramen

The television cameramen have come and gone. The lights have been put away; there will be a filmed story on the early evening news. Reporters from the daily newspapers, with ruled notebooks instead of strobe lights, are still reporting. The ones representing the afternoon or out-of-town papers, and reporters from the wire services, have slipped out and filed early stories. Some of them are back now; there's more to come.

Radio newsmen hover outside the Board room waiting for the meeting to break up. Their tape recorders will carry the voices of key Board members to the people of Georgia this afternoon and into the evening, explaining the significance of actions here today.

"Medicaid"

Dr. Venable's report also refers to the Department's new responsibility, Title 19—"Medicaid." As the Health Department has just assumed direction of the program—it was assigned by the governor in August—Dr. Venable simply reports that the state Medical Assistance plan has been submitted to Washington and that he is awaiting official U.S. approval.

He assures the Board that the program will go into effect October 1, the original target date.

Several Board members indicate specific changes that will probably be required in the Medicaid program, but voice agreement that modifications should be deferred until the end of the first nine months of operation. At the end of the "shakedown cruise," July 1, 1968, changes will be included in the plan, which would then be submitted under full Health Department authorship.

A great deal of discussion concerning the new program had gone on between Board members and the Department's top administrators in earlier meetings —both in full session and in committee.

Wednesday Is Committee Day

Although full Board meetings are scheduled for each third Thursday throughout the year, members are actually involved for two days—plus study, research and reading time on their own. On the Wednesday preceding each month's meeting date the members gather for committee sessions. Here information is assembled and tentative conclusions drawn for discussion and decision by the Board on Thursday. No official Board action is taken except in full session.

Thursday, September 21, is running out. Dr. Elton Osborne, the Health Department's deputy director, submits a concise report on pending and possible legislation upcoming in the 1968 General Assembly. This is preliminary; the subject, with more specifics, will recur at later meetings as January approaches.

The Board members are also informed by Dr. Osborne that all of the Department's tuberculosis control and treatment efforts will be centered at Battey State Hospital in Rome, effective October 1. This is simply an administrative procedure, confirming previous Board action.

Lunch time is approaching, but the Board usually eats late on meeting day, subsisting on coffee and work until the last item is ticked off on Dr. Dixon's agenda. It's time now for reports from committee chairmen.

From these committees: Medical Care Administration, Mental Health, Physical Health and Epidemiology and the Chairman's Committee, come many of the results of hard fact-finding and debate.

From the Medical Care Administration group come documents concerning health related advisory councils that require Board of Health approval. On a motion by Lee Roy Claxton, Griffin pharmacist, seconded by Dr. Richard Smoot of Decatur, minutes are approved as submitted from meetings of the Radiation Control Council, the Hospital Advisory Council, the Food Service Advisory Council and the Georgia Water Quality Control Board.

"Instant Experts"

In bantering comment on the variety of subjects laid out before the Board, one member wryly observes that when he became a member he had no idea that he would find it necessary to become an "instant expert" on so many subjects. So be it. Back to the official papers.

COMMITTEES GEORGIA STATE BOARD OF HEALTH AS OF DECEMBER 1, 1967

CHAIRMAN'S COMMITTEE
(Handles executive matters, represents Department with Governor and Legislature)
- Dr. P. K. Dixon—9th District
- Dr. J. T. Mercer
- Dr. John E. Martin—10th District
- Mr. Carl E. Pruett
- Mr. Harrison W. Bray

MENTAL HEALTH COMMITTEE
- Dr. B. W. Forester—6th District
- Dr. William A. Dickson—8th District
- Dr. Roy L. Gibson—3rd District
- Dr. Albert C. Tuck
- Mr. John E. Garner, Jr.

PHYSICAL HEALTH AND EPIDEMIOLOGY COMMITTEE
- Dr. Julian K. Quattlebaum—1st District
- Mr. John D. Marshall
- Dr. Earl McGhee—7th District
- Dr. Wesley A. Carr

MEDICAL CARE ADMINISTRATION COMMITTEE
- Dr. Richard H. Smoot—4th District
- Mr. Lee Roy Claxton
- Dr. Lamar Peacock—5th District
- Dr. Frank McKemie—2nd District

EXECUTIVE COMMITTEE
(Composed of officers of the Board and Committee Chairmen)
- Dr. P. K. Dixon
- Dr. B. W. Forester
- Dr. J. T. Mercer
- Dr. Julian K. Quattlebaum, Jr.
- Dr. Richard H. Smoot

SUBCOMMITTEES:
Dental, Dr. Albert C. Tuck
Pharmacy, Mr. John Marshall
Veterinary, Dr. J. T. Mercer
Legislation, Dr. Richard H. Smoot

The eighteen-member State Board of Health includes ten medical doctors, one representing each of the ten districts. In order to fill a position on the Board, the district medical society nominates three people. These names are approved by the Medical Association of Georgia and forwarded to the Governor of Georgia who chooses one of the three to serve on the Board. If the Governor does not want any of the three, he may send the nominations back to the district society with a request for three more. These three are approved by MAG and sent to the Governor who must choose from the total of six names submitted to him. Each member of the Board serves a six-year term.

Discussion goes on into the early afternoon. Included is official approval of the Georgia State Plan for Hospitals and Medical Facilities—required to bring Hill-Burton funds to Georgia for medical construction.

The Board members who are physicians are particularly concerned here. They know first hand the difficulty in securing beds for their patients, the long delay in scheduling elective surgery.

But the lay members are vitally concerned too. They are community leaders "back home" and know intimately the problems that bed shortages create—in hospitals and in nursing homes.

The State Plan is not new. The members have had copies of the tentative version for several months. It has been studied and discussed before in an attempt to reach a just and equitable method for dispensing state and federal funds—to be matched with local dollars. It has had several modifications. A member leans back in his chair. Have we done the best we know how? I think so. Here's the vote. "Aye." The "ayes" have it. The plan is approved.

And Finally the Budget

And now here comes the budget for fiscal '69. It will total $173,306,807 in combined state and federal funds when it is finally approved by the Board. The biggest item is Medicaid—$71,783,975. It's a bargain for the state; $66 million will come from the federal government.

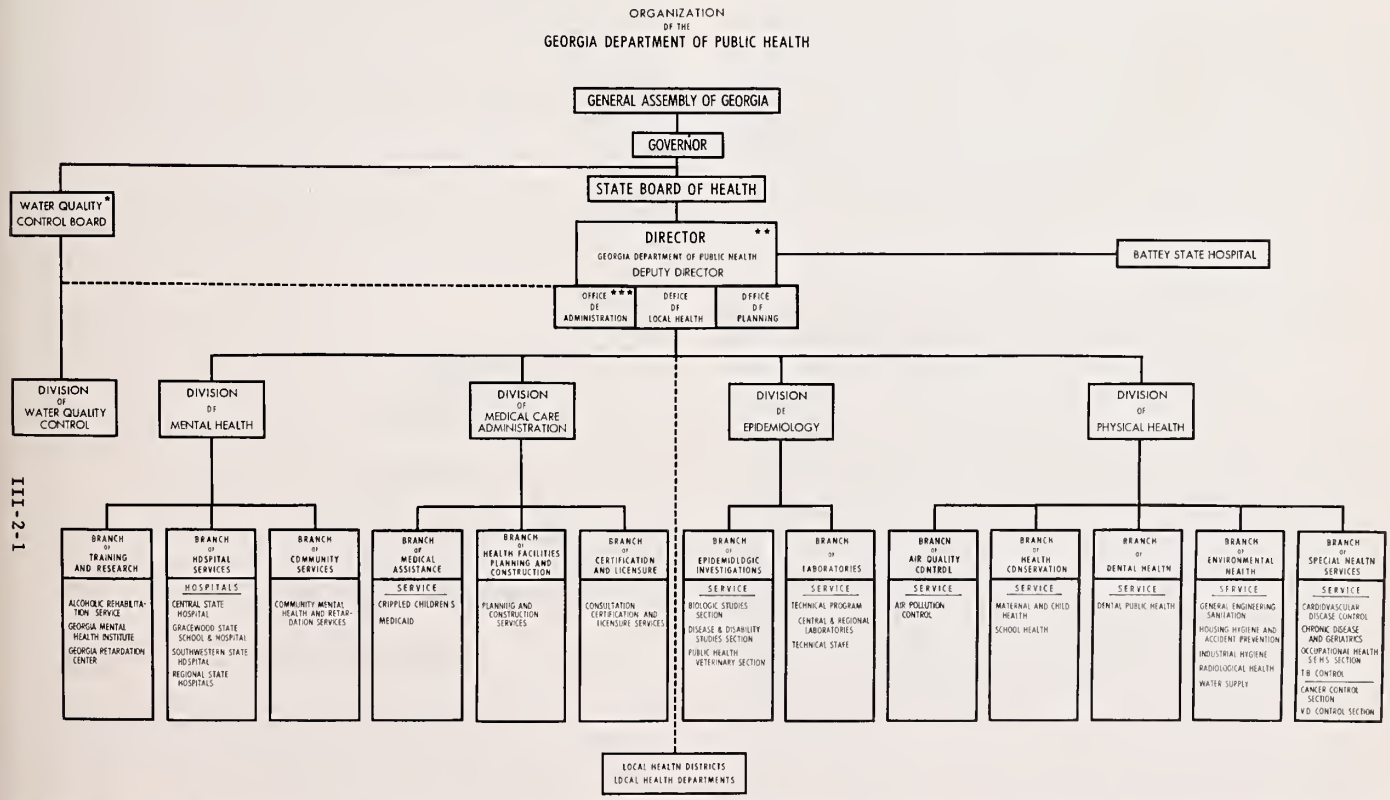
And Milledgeville—now Central State Hospital—is in for over $33 million. This includes, at last, a new surgical unit for the hospital. It's desperately needed.

But wait a minute. What's this item on the first page of proposal "M"? Why $225,000 capital outlay at Southwestern State? We'd better check out the advantages and disadvantages of that when we go to Thomasville in November.

It's 2:20, way past lunch time. The member takes off his glasses and rubs his eyes. Maybe we'll be through by 3:00. It's a long drive back home, and I have surgery at 7:00 in the morning.

He turns for a moment and glances out the window. A long, lazy stream of black smoke is hugging Atlanta's south skyline, drifting from a tall brick smokestack. That's something else we'd better look into. Those air pollution rules and regulations should be ready by January.

There's no doubt about it; we've got to do something.



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The State Board of Health is responsible only to the Governor and the General Assembly of Georgia. The Georgia Department of Public Health is under the control of the State Board of Health, the majority of whose members are medical doctors. The Committees of the Board meet each Wednesday and their recommendations are presented to the entire Board at the monthly meeting.

The primary problem in adult congenital heart disease today is that of early recognition.

Adult Congenital Heart Disease Analysis of 206 Patients

PAUL E. CUNDEY, JR., M.D., *and* JOHN H. EDMONDS, JR., M.D., *Augusta*

ADULTS WITH CONGENITAL HEART DISEASE present themselves not infrequently for diagnosis and treatment. From July 1956 through June 1966, 206 adults with congenital heart disease, representing 0.27 per cent of the total admissions, were evaluated at the Eugene Talmadge Memorial Hospital.

Although acquired heart disease forms the bulk of the adult cardiovascular disease spectrum, the diagnosis of congenital cardiovascular anomalies is of great importance since the advent of modern cardiovascular surgery. With present surgical techniques, most patients with these lesions can be cured or offered significant palliation. Therefore, accurate diagnosis and recommendations for appropriately indicated and timed surgical intervention have much to offer adults with congenital heart disease.

Material

The protocols of all patients over the age of 18 years with a code diagnosis of congenital heart disease were examined. In 206 patients the diagnosis was considered to be firmly established. The majority underwent cardiac catheterization and/or surgery. In a small number the diagnosis was established at necropsy. Approximately 5 per cent of the patients were included on the basis of typical clinical findings. Particular attention was paid to symptomatology, history, physical findings, chest roentgenograms, and electrocardiograms as aids in arriving at a correct diagnosis. Operative results and non-operative courses are presented where the data was available. The anomalies seen and their respective incidences are given in Figure 1.

Fifty-nine cases of the secundum type of atrial septal defect were studied. This accounts for 28.8 per cent of the total, a figure which correlates closely with a previously reported clinical study.[1]

Age, sex, and racial distribution are depicted in Table I. Seventeen patients, or 28.3 per cent, were over 40 years of age. Of further note, two patients were in their mid-sixties when first seen. One patient had successful surgical repair of her lesion at age 66 and experienced significant clinical improvement.

Clinical diagnosis remains a problem in this disorder. Forty of the 59 patients were admitted with a specific referral diagnosis, of which 18 were incorrect. Nineteen patients were categorized simply as congenital heart disease on referral. Thus 37 pa-

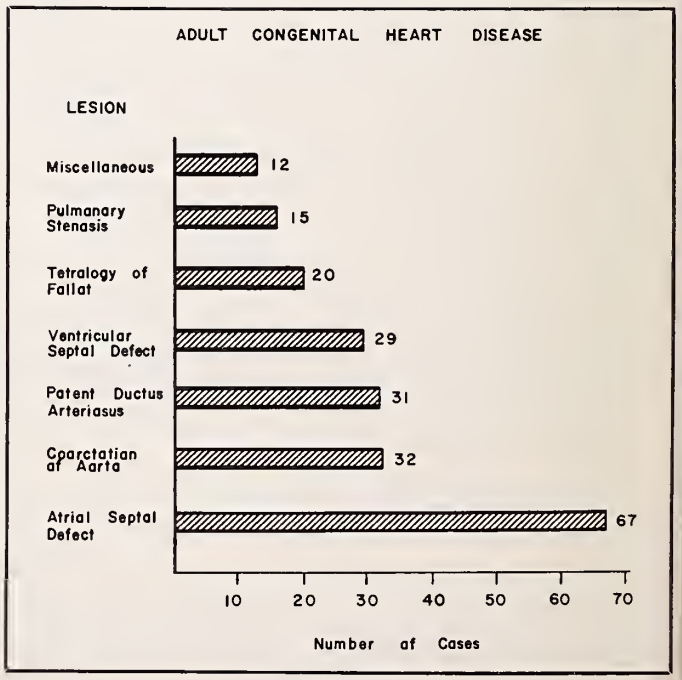

FIGURE 1

From the Division of Cardiology, Department of Medicine, Medical College of Georgia, Augusta, Georgia 30902.
Supported in part by PHS Grant HE 5442-08.

tients, or 62.7 per cent, were referred with an incomplete or incorrect clinical diagnosis.

Clinical findings found to be of diagnostic value included: (1) a systolic ejection murmur located in the second or third left intercostal space, 55/59 or 93.2 per cent; (2) a prominent pulmonary artery segment on chest x-ray and increased pulmonary vasculature 50/59 or 84.7 per cent; (3) an rSr′ or diastolic overload pattern in V_1 40/59 or 67.8 per cent.

Fourth Decade Marks Rise

The incidence of congestive failure rose dramatically in the fourth decade. Sixteen patients presented in congestive failure and 14 of these were over age 30. Forty patients underwent surgery and there were two deaths in the immediate post-operative period. Three patients not having surgery are known to have died during the period of study. One of these had active bacterial endocarditis at death and another suffered cardiac arrest during angiocardiography. The terminal event in the third case is not known but the patient was in severe congestive heart failure when last seen.

In eight cases, atrial septal defect of the primum type was diagnosed. In all patients a regurgitant murmur was present at the apex. Four patients exhibited left axis deviation on their electrocardiograms. These patients tended to develop congestive failure at an earlier age than those patients with a secundum type defect. Surgery was performed on seven patients. One succumbed to bacterial endocarditis at the site of a prosthetic mitral valve some five months after the original surgery despite prolonged anti-microbial therapy, removal of the original prosthesis and reimplantation of a second prosthetic valve.

Complicating lesions were common in both types of septal defect. Anomalous pulmonary venous drainage was present in 15 cases, pulmonary stenosis in two, and mitral stenosis in one.

In the patients not having surgery, bacterial endocarditis occurred twice. In one of these patients paradoxical embolization resulted in death.

There is a striking difference in the incidence of atrial septal defect in this series versus previously reported autopsy studies.[6, 7] Bias is inherent in both populations but the difference is considered significant and is indicative of a substantial reservoir of adults with atrial septal defect.

Morbidity increased with age and the incidence of congestive heart failure was particularly noteworthy in the fourth decade of life. Factors related to failure in these patients included: (1) size of defect; (2) magnitude of left to right shunt; (3) pulmonary artery pressure greater than 50 mm. Hg.; (4) age. In a small number of patients modest pulmonary hypertension appeared protective in regards to congestive heart failure.

Coarctation of the Aorta

This anomaly was present in 32 patients. Age distribution is demonstrated in Table I. Nineteen patients were male and 13 were female. A distinct racial imbalance was noted with only four non-whites in the group. This imbalance did not occur in any other grouping in the present series and does not correlate with the ratio of white to non-white admissions to the hospital, which for the period of study was essentially 1:1.

Symptomatology, while generally non-specific, did include the combination of headache and dyspnea in six patients. This symptom complex was not seen in patients with other congenital cardiac lesions. Twenty-two patients, or 68.7 per cent, were referred with the correct diagnosis. It was noted that 17 of these 22 patients exhibited rib-notching on chest x-ray. The electrocardiogram was abnormal in 24 cases. Left ventricular hypertrophy was the most frequently recorded abnormality.

The physical finding of decreased or absent femoral pulses was present in all cases, and the blood pressure in the legs when recorded was below that recorded in the arms. A physical finding that correlates well with the presence of aortic obstruction, namely delay in the femoral pulse,[2] was infrequently recorded either by the referring physician or in the initial in-patient examinations.

Surgery was performed on 27 patients with two in-hospital deaths for a mortality of 7.4 per cent. A high incidence of associated anomalies was present, including seven with bicuspid aortic valves and five with patent ductus arteriosus.

There were two known non-operative deaths during the period of follow-up. Bacterial endocarditis on an associated bicuspid aortic valve accounted for one death and congestive heart failure the other.

Patent Ductus Arteriosus

Thirty-one patients were seen with this anomaly. Twenty-five females and six males comprised this group. The referral diagnosis was correct in 20 instances and unspecified in nine. Six patients in the present series were admitted in congestive heart failure and four of the six were over 25 years of age.

Twenty-six patients were operated upon and there were two postoperative deaths. Angiocardiography had demonstrated a Sinus of Valsalva aneurysm in addition to a patent ductus in one patient who presented with active bacterial endocarditis. At surgery the right coronary artery cusp of the aortic valve was found to be the site of apparently healed bacterial endocarditis. A congenital sinus extending from

the left aortic sinus into the right atrium was also present. The patient did poorly after surgery and died 18 hours postoperatively. The second patient was found to have an extremely friable aortic wall at surgery. The aorta tore during attempted cross-clamping and cardiac arrest occurred during repair. Resuscitation was unsuccessful.

Three additional patients in this group had well-documented bacterial endocarditis. Two were admitted with active disease, treated, and underwent successful surgery. One 66-year-old lady presented with her second episode of bacterial endocarditis and in congestive heart failure. She responded well to appropriate medical therapy but declined surgery.

Ventricular Septal Defect

The natural history of this congenital lesion has been debated extensively in recent years. Wood, et al,[3] pointed out in 1954 the relative infrequency of this lesion in his series. He found that uncomplicated ventricular septal defect accounted for only 8 per cent of the lesions in 750 cases of congenital heart disease. This was a significant departure from the previously held concept that this was the most common congenital cardiac lesion. Brotmacher and Campbell[4] analyzed 75 cases proven by cardiac catheterization and devised a functional classification based on size of the defect and magnitude of the shunt. Further, they indicated that few patients would survive to age 40. Bloomfield[5] subsequently correlated course with defect size and suggested a much more favorable prognosis.

In the present series this congenital defect was documented by cardiac catherization, surgery, or necropsy study in 20 patients. The pertinent statistical data is included in Table I.

A specific referral diagnosis was present in 19 instances and 13 were correct. Eleven patients demonstrated the "typical" murmur associated with this anomaly, that is, a grade III or greater pansystolic murmur in the third lift intercostal space. A thrill was present in the same location in seven cases. The absence of this clinical hallmark in 13 patients could not be attributed to the presence of congestive failure, pulmonary hypertension, or associated lesions.

The chest x-ray was abnormal in 17 patients with cardiomegaly and increased pulmonary markings being the pertinent findings. The electrocardiogram was abnormal in 16 patients with left ventricular hypertrophy in nine and combined ventricular hypertrophy in seven.

Four patients were in congestive heart failure when first seen. Two exhibited a relentlessly progressive course and died within six months of their initial hospitalization here. One patient survived three years following surgery and the fate of the fourth patient is unknown.

Pulmonary hypertension of varying severity was found in seven patients. All were moderately to severely symptomatic. Four underwent surgery and three are living and well one to eight years postoperatively. The fate of the fourth is unknown.

Two additional patients with significant left to right shunts had successful surgery. Thus, of seven patients having surgery, five experienced substantial palliation and two were essentially cured.

Four of the 20 patients are known to have died. As previously mentioned, three had severe cardiac failure when first seen. The fourth patient had severe pulmonary hypertension and a right to left shunt. The clinical course was rapidly progressive with death occurring within two years.

TABLE 1

CONGENITAL HEART DISEASE IN 194 ADULT PATIENTS*

	Atrial Septal Defect Secundum	Atrial Septal Defect Primum	Coarctation	Patent Ductus	Ventricular Septal Defect		Tetralogy	Pulmonic Stenosis
Sex								
M/F	22/37	3/5	19/13	6/25	13/7	7/2	9/11	7/8
Race								
W/NW	17/42	4/4	28/4	22/9	8/12	6/3	13/7	12/3
18-20	8	0	5	5	3	1	7	3
21-30	22	3	12	17	11	4	10	5
31-40	15	2	6	5	6	4	2	4
41-50	8	2	8	3	0	0	1	3
>50	6	1	1	1	0	0	0	0
Totals	59	8	32	31	20	9	20	15

*Does not include miscellaneous group of 12 patients.

Bacterial endocarditis occurred in four of the 20 patients and played a major role in the demise of two.

In nine additional cases the diagnosis of ventricular septal defect was accepted on clinical grounds alone. Five of this group had the typical murmur and thrill identified with Roger's disease and were asymptomatic. In addition, in each case the murmur was known to have been present since early childhood. Two of these five patients, ages 25 and 23, have been followed three and two years respectively, and there has been no change in their clinical course.

The remaining four patients presented in congestive failure. Their evaluation was not completed for various reasons and the diagnosis was established on the basis of murmur, thrill, roentgenogram suggesting left to right shunt, and the electrocardiogram.

Tetralogy of Fallot

Twenty patients were seen with this anomaly, the oldest being 44. Sixteen patients were clinically cyanotic when first seen. Most gave a history of severe dyspnea and squatting during childhood. A left parasternal lift and a systolic ejection murmur in the pulmonic area were present in 16 patients. The electrocardiogram was abnormal in all patients and demonstrated right ventricular hypertrophy with a systolic overload pattern in 16.

Thirteen patients were treated surgically and there were six postoperative deaths. All patients not surviving surgery were severely cyanotic and had marked polycythemia. Of the seven patients not having surgery, two have been followed for five and four years respectively with gradual deterioration. Another patient died of bacterial meningitis and four were lost to followup.

Pulmonic Stenosis

Isolated pulmonic stenosis was sixth in frequency in this series occurring in 15 patients. Although these patients constituted the most homogenous group studied, the referral diagnosis was correct in only four instances. Thirteen of the patients were found to have the characteristic pulmonic ejection murmur. A thrill in the pulmonic area was present in eight patients. The chest x-ray demonstrated a prominent pulmonary artery segment in 10 and the electrocardiogram revealed right ventricular hypertrophy of the systolic overload type in 13 patients.

Five patients had successful surgical repair. Of the remaining 10 patients, four have been followed from one to eight years without change in their clinical courses. Two have slowly deteriorated over this period and three have not been followed.

One death occurred in this group. The patient was in severe congestive failure when first seen and had been diagnosed several years previously as having mitral insufficiency. Initial clinical evaluation revealed the presence of pericardial effusion and suggested the possibility of pulmonary stenosis. Cardiac catheterization confirmed the presence of right ventricular outflow tract obstruction. The patient expired before corrective surgery could be carried out. Pericardial effusion was present at post-mortem examination and severe pulmonary valvular stenosis.

Miscellaneous

Twelve patients with a variety of defects comprised the remainder of the series. Seven patients were considered to have congenital aortic stenosis. There were five males and two females in this group and the age range was from 25 years to 43 years. Four patients had knowledge of a murmur dating to late childhood. Symptomatology was remarkably uniform, all patients complaining of rapidly progressing dyspnea and three of angina pectoris. Cardiomegaly was present on x-ray in six patients and a prominent ascending aorta in four. The electrocardiogram, as expected, revealed left ventricular hypertrophy.

Three patients were operated upon and there was one operative death.

Two patients with Ebstein's anomaly were seen, ages 29 and 42. One died during attempted angiocardiography and the other was lost to followup.

Sinus of Valsalva aneurysm was present in two patients. One had a documented history of a continuous murmur being present 10 years before an episode of bacterial endocarditis. At surgery a ruptured sinus aneurysm was found and five years later the patient is asymptomatic.

Total anomalous pulmonary venous drainage was encountered in one patient who died shortly after an atrial septal defect had been surgically created in an attempt to relieve his severe hypoxemia.

Bacterial Endocarditis

Bacterial endocarditis occurred in 19 patients. Incidence related to age and lesion is shown in Table

TABLE II
BACTERIAL ENDOCARDITIS

	Total No.	Age Distribution 18-30	31-50	> 50
Atrial septal defect	5	3		2
Ventricular septal defect	4	4		
Coarctation of aorta	2		2	
Patent ductus arteriosus	4	3		1
Tetralogy of Fallot	1		1	
Aneurysm, Sinus of Valsalva	1	1		
Aortic valve (bicuspid)	2	1	1	
	19	12	4	3

11. Three patients experienced more than one episode. Seven deaths were closely related to the endocarditis and there was clearcut deterioration in nine others.

Summary

Two hundred and six adult patients with congenital heart disease have been reviewed. The data suggests that the primary problem in adult congenital heart disease today is that of early recognition. History, physical examination, chest x-ray and electrocardiogram are sufficiently characteristic to permit clinical diagnosis in most patients. Cardiac catheterization and cineangiography provide more precise anatomical and physiological data and are particularly helpful in the detection of multiple anomalies.

Early recognition permits prompt and often curative surgery. The composite surgical mortality for patients with atrial septal defects, coarctation of the aorta, patent ductus arteriosus, ventricular septal defect and pulmonary stenosis was 5.7 per cent. This experience corresponds favorably with the recently reported series of Cooley and Hallman in similar age groups.[8]

Successful management of the adult with congenital heart disease consists then of early diagnosis, careful observation and appropriately-timed surgical intervention.

Acknowledgement

The authors express their appreciation to Dr. Robert E. Ellison, Professor of Thoracic Surgery, who was responsible for those patients having surgery, and to Dr. Robert L. Rainey, Assistant Professor of Medicine, who performed many of the cardiac catheterizations.

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MEDICARE REPORT

The Social Security Administration, in cooperation with the American Hospital Association, has developed a new method of paying for hospital services under medicare, John W. Gardner, Secretary of Health, Education, and Welfare, announced recently.

Beginning January 1, 1968, Gardner said, hospitals will be able to count on receiving an agreed-upon uniform medicare payment each week. This new method, which may become a prototype for other hospital insurance plans, will help hospitals improve their financial planning and day-to-day management and substantially reduce detailed paperwork.

Detailed statements of services and charges will no longer be required in advance of medicare payment, the Secretary noted. Instead, a hospital's weekly payment will be based on an estimate of the cost of the services it expects to furnish to medicare beneficiaries in the course of a year. It will receive that amount weekly in 52 installments.

Adjustments in the amount of the payment can be made at any time to reflect current cost experience. Final settlement and audit will take place once a year.

There were over 6 million admissions to hospitals under medicare during the first 15 months of its operation, he said, involving about 5 million people. Over $3 billion has been paid to hospitals for these services.

Physicians have arranged home health care for about 300,000 people, and since January 1, about 300,000 people have been admitted to extended care facilities.

About a billion dollars has been paid under the voluntary program which covers primarily physicians' bills. The somewhat over 20 million bills for physicians' services, covering a great variety of services, have averaged $38 each. The surgical bills, as would be expected, were considerably more and taken alone averaged about $132 per bill.

There are about 6,900 hospitals participating in the program, about 4,200 extended care facilities, 1,900 home health agencies, and 2,400 independent laboratories. Seventeen and three quarter million people over 65, or 93 percent of all the older people in the country, have enrolled in the voluntary medical insurance part of medicare.

Processing time for the payment of claims has been greatly reduced in recent months, Secretary Gardner stated. The average time nationally required to process physicians' bills is now about two weeks. This is a reduction, he said, from an average processing time of about 5 weeks at the first of the year and about 2½ weeks in June.

U.S. Department of
Health, Education, and Welfare

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It stands to reason. They all go through the same training; they all have to pass the same tests; they all have to measure up to the same standards; they all are underpaid, too. Therefore, all interns are alike.

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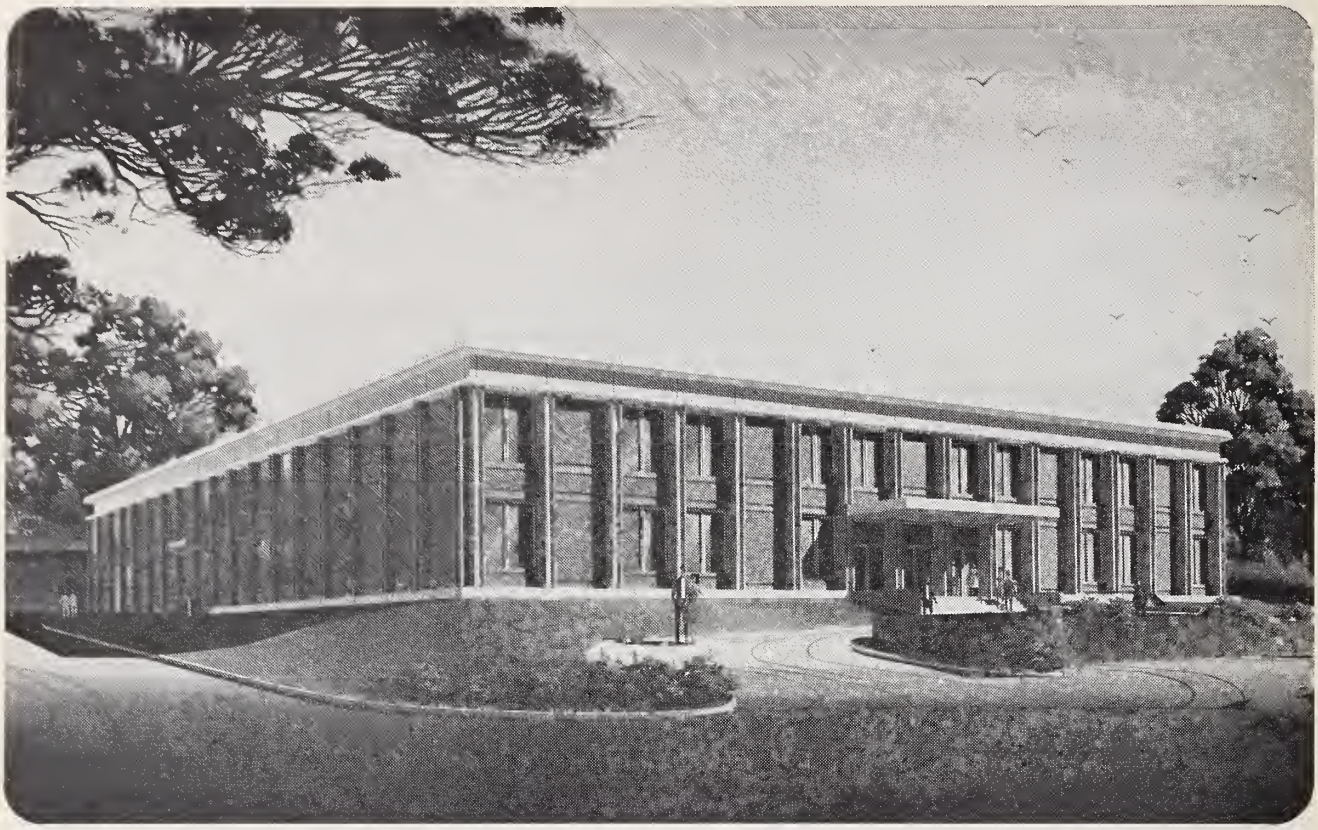
So next time you hear someone say that all aspirin tablets are alike, you can say, with confidence, that it just isn't so.

You might also say that all interns aren't alike, either.



New, Long-term Psychiatric Facility

The new forty bed Parkwood Hospital specializes in long-term treatment of the mentally ill. Under the direction of a Medical Director, the hospital facilities are available to over thirty psychiatrists who are on its staff. Parkwood provides a full complement of exceptional facilities including X-ray, laboratory, pharmacy, occupational and music therapy, patient beauty parlor and an outdoor recreational area. ☐ Special efforts were made to combine maximum patient comfort with a warm, secure, residential atmosphere readily conducive to psychotherapy. ☐ We will be pleased to provide further information upon request.

Accredited by the Joint Commission on Accreditation of Hospitals

PARKWOOD HOSPITAL

1999 Cliff Valley Way, N.E. / Atlanta, Georgia 30329 / Phone 634-5166 (404)

Emphasis is placed on primary closure either by direct suture or by skin grafts.

Skin Coverage for the Traumatized Hand

GRADY S. CLINKSCALES, JR., M.D., *Atlanta*

THE UNIQUE SENSIBILITIES which the skin of the hand provides are taken for granted until a laceration, an avulsion, or some other such injury either removes a portion of this cover, or so severely impairs its function that replacement becomes necessary. It is under these conditions that we realize the importance of restoration, and the difficulty of restoring its function completely.

The elastic properties of the skin vary considerably from the dorsum of the hand to the palm. On the dorsum, it is frequently possible to advance skin margins one to the other for a primary closure and thus eliminate the necessity of a time consuming and sometimes unpredictable skin graft. On the other hand, when skin replacement is necessary we must choose the type of procedure that will be most satisfactory for that particular wound for that particular person. We must consider not only the size of the defect created by the trauma but also its location and the degree of contamination. The time interval from injury to surgery, the occupation of the patient, and the experience of the surgeon are also determining factors.

Let us then with illustrative patients mention a variety of methods for re-covering lost skin, first, on the finger tips, then on the shafts of the digits, next over the dorsum of the hand, over the palm, and after extensive loss from severe injuries. Although the points which will be made here deal primarily with skin coverage alone, one should always keep in mind that injuries to the contiguous vessels, nerves, tendons, and skeleton are frequently associated, and should always be appraised before the definitive skin coverage is obtained. General surgical principles of evaluation, debridement, irrigation, dressing, and immobilization are applied as always. Specific applications of these will be mentioned as we go along.

Finger-Tip Loss

Even on the tips of the fingers, skin margins must be debrided, but such debridements should be meticulous and limited. Pulp loss, if not extensive, may be filled with a free split-thickness skin graft from a readily available site, such as the forearm. This may be taken with a razor blade and hemostat. A thin split graft will shrink some 50 to 75 per cent and thus minimize the size of the defect. Transverse tissue loss at the tip, including not only pulp skin but finger nail as well, can also be covered with a split-thickness skin graft. The more proximal on the nail, the more bulbous the deformity and the more beaking of the nail that may subsequently occur. Sensation on the finger tip gradually returns to a degree, but is more normally provided by another technique —that of floating two triangular flaps of skin from each lateral aspect of a damaged finger tip. This is performed by making a V-shaped incision on each side, advancing the flap of skin with its under attached neurovascular pedicle across the tip of the damaged finger, and by suturing the two flaps in place. The V-shaped incision, when sutured, thus becomes Y-shaped.

Cross-Finger Flap

Alternatively, a finger tip may be reconstructed in part by filling the defect with a cross-finger flap from an adjacent digit. Dorsal skin is raised with its base on the side of the recipient digit and the flap of

Presented at the 113th Annual Session of the Medical Association of Georgia, April 30, 1967, Atlanta.

FIGURE 1

Avulsion of entire soft tissue from volar aspect of index finger tip.

skin sutured into the defect on the volar surface. See Figures 1 and 2. The donor wound is also then converted into a closed wound by a split-thickness skin graft taken from the forearm. See Figure 3. Small Kirschner wires may be necessary to aid immobilization of the fingers in the desired position for two to three weeks. The resultant graft usually molds nicely, affords protective cover, and usually develops crude sensation. Note that the reversal of this procedure is not recommended—that is, volar skin should not be donated to a dorsal wound on a digit.

Terminal amputations, particularly if they are oblique, creating a denuded area more dorsal than volar, and particularly if they involve either the middle or ring finger, may be treated by attaching a local flap from the thenar eminence. The donor site is in turn covered with a split-thickness skin graft, the injured finger tip sutured into the flap in an acutely flexed position, and an immobilizing dressing applied. The flap is detached two to three weeks later. This is a procedure to be used for the younger person, in whom joint stiffness is not likely to be a problem. One must recognize that the thenar area remains scarred and may be somewhat tender.

Preserving Length

It is particularly important to preserve length of any digit wherever possible, and this is all the more important for the thumb. When circumferential tissue loss leaves bare bone and tendon exposed, pedicled skin from a distant flap is an ideal way to preserve length and obtain a tough padded cover. This may be obtained from the pectoral or the abdominal areas. Pectoral pedicles offer the advantage of better quality skin and a greater mobility for the patient during the three weeks of immobilization. Two three-sided flaps are raised, one based proximally, one based distally on the side of the chest opposite the injured hand. The flaps are advanced toward each other, forming a stem, and the denuded tip sutured into the pocket. After detachment twenty-one days later, the skin is noted to provide a good tough cov-

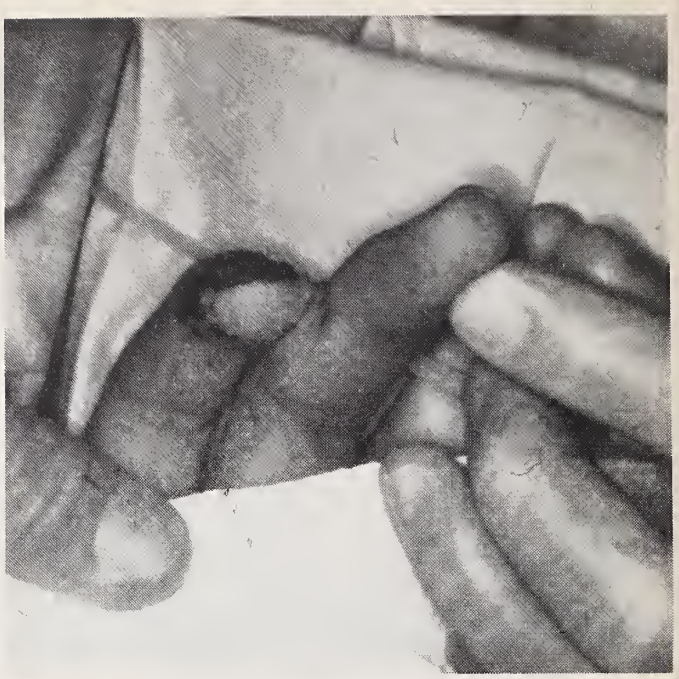


FIGURE 2

Completed cross-finger flap just prior to detachment. Base of flap is along the radial aspect of the middle finger at its middle phalanx.

FIGURE 3

Dorsal aspect of the completed flap showing the healed split thickness skin graft to cover donor area on dorsum of middle finger.

ering that is gradually complimented by enough sensation to be protective but not refined.

If the finger tip damage has been extensive, is in a laborer, and is one of the non-dominant fingers, it is frequently advisable to obtain a primary closure by sacrificing the distal joint. The digital nerves are cut one-fourth inch proximal to the amputation and the skin margins advanced over the stump.

When multiple finger tips are involved, the damage is frequently at varying levels and a combination of procedures must be employed. One finger tip may be covered with a split-thickness skin graft while another finger may require an amputation. Other digits, if degloved, can be preserved length-wise, for example, by syndactylizing the two digits in a double pedicle abdominal flap. The flap is detached three weeks later. After this wound is healed, the syndactyly is released, and the finger tips revised by defatting and tapering the transferred tissue.

Skin Loss on Shafts of Digits

More proximally on the digits, skin may be reapproximated and the wound closed by primary suture in spite of the initial appearance of the wound. If more avascular structures, such as tendon or bone, remain exposed, a transposition flap may be used to close the defect. This type of coverage carries with it its own subcutaneous padding and its own blood supply. Donor defects thus created are then filled with a split-thickness skin graft taken from the forearm.

When damage involves not only extensive crushing lacerations of the skin but also the underlying vascular supply, the entire distal portion of the digit may not survive even though the local skin wound heals. This, of course, necessitates amputation. The ischemic portion of the digit is removed by filleting it from the remaining viable skin, which in turn is reflected over the stump to provide not only adequate cover but sensation as well.

Amputation in Severe Injury

If the injury has been severe and is accompanied by damage to any combination of three of the five tissues involved (skin, vessels, nerves, tendons, and/or bone), an amputation may be advisable. In the index finger, this can be tapered cosmetically by an oblique ostectomy through the base of the second metacarpal, re-attaching the first dorsal interosseous tendon into the radial aspect of the middle finger extensor mechanism. If the digit has been completely degloved, and especially if it is a little finger, this may also be amputated and the hand tapered similarly.

When skin has been avulsed from the proximal shaft of a digit, particularly along the dorso-radial aspect of the index finger, a cross-arm pedicle flap affords excellent coverage. The flap is detached three weeks later and is further supplemented after complete skin wound healing by nerve, tendon, and further bone or joint repairs when necessary.

Skin Loss on the Dorsum

The skin on the dorsum of the hand is quite mobile and in spite of the initial appearance of an extensive laceration, the skin may be advanced to permit primary suture merely by dorsiflexing the wrist.

Circular ischemic defects on the dorsum of the hand, which occasionally accompany massive hematoma formation, must be excised. Their defects can be closed with a split-thickness skin graft which characteristically diminishes in size as the scar matures.

Avulsed flaps of skin on the dorsum of the hand may survive completely if they are based proximally or laterally. If they are based distally, or if there has been extensive contusion of the skin in the process, tissue edema and vascular thrombosis preclude its complete survival. Even though the skin may be closed primarily, it must be watched over the next few days to determine the extent of its viability. Rather than waiting several weeks for complete demarcation to occur with granulation tissue formation, possible infection, and scarring, one may proceed immediately with excision and replacement with a split-thickness skin graft, and thereby shorten the duration of recovery. Suture lines along the webb spaces, and in particular the first webb space, should be accompanied by extensions onto the volar aspect to interrupt the line of possible contracture. Skin grafts of this size may be taken with any of a number of types of dermatomes, but the electric machines available now are easy and rapid. The thinner the graft, the more likely the take, but the greater the shrinkage. If the wound should cross a flexion crease, this contraction may result in a flexion deformity. The thicker the split-thickness skin graft, the less the contracture, but the more unpredictable its survival. The quality of coverage is proportional to its thickness.

With roller injuries, the skin on the dorsum may not actually be torn because of its elasticity but it may be sufficiently crushed and rubbed against the underlying skeleton so that it is avulsed from its deeper attachments. The contusion results in swelling, thrombosis of small vessels, and ultimate skin necrosis with sloughing. The skin must be debrided to the limits of its necrosis and replaced with a medium split-thickness skin graft if the tendons are still covered by their paratenon.

Skin Loss on the Palm

Wounds on the palmar aspect of the hand may also be closed by direct suture many times, but tis-

FIGURE 4

Note also that the distal palmar skin is ischemic and was debrided prior to application of the graft.

sues are less mobile. Deep lacerations which create a retrograde flap based distally survive better than similar ones on the dorsum, but still heal with considerable fibrosis and scar contracture. The retrograde flap may be deceiving in its initial appearance. The skin loss may be minimal but the undermining of tissues may be occult until the patient is anesthetized and closer inspection of the wound can be carried out. It may be impossible to determine the level of demarcation initially. In such instances, if primary closure can be obtained, this may be done. The wound is then inspected twenty-four to forty-eight hours later, and as soon as demarcation is beginning to appear, the wound may then be further debrided and replaced with the desired coverage. See Figure 4.

FIGURE 5

Outline of flap to be created.

If the deeper structures of the palm are exposed, a pedicled graft is frequently advisable. The pedicled flap may be developed from the lower abdominal quadrant, preserving the epigastric vessels or from the upper abdominal quadrant, preserving the thoraco-epigastric vessels. See Figure 5. The midline of the abdomen is not crossed. The skin edges are undermined, advanced, and the donor site is reduced in size by echelon suturing. Any remaining defect is converted into a closed wound by split-thickness skin grafts. The pedicle flap which carries with it its own vasculature embedded in subcutaneous tissue is then sutured onto the palm. After detachment, the skin margins of the abdomen can be further advanced to reduce the donor site still more. If the patient should gain weight subsequently, the adipose tissue of transposed skin to the palm accumulates fat in the same manner as its original donor area and may require defatting at a later date.

Wringer Injuries

Wringer injuries frequently damage both palmar and dorsal aspects of the hand. Because the palmar skin is firmly fixed to its deeper structures by thick fibrous bands, this skin may be literally torn from its base, creating a retrograde flap. The dorsal skin, on the other hand, being much more pliable and less fixed to its underlying structures, may not seem torn by external appearance but typically would slough. In these circumstances, the retrograde flap from the palm must be debrided along with necrotic dorsal skin. If the tendons and neurovascular bundles are exposed in the palm, the defect can then be replaced with an abdominal pedicle flap, while the dorsum of the hand is covered with a thin split-thickness skin graft.

Complications

The complications after skin trauma and grafting, as you have already expected, are contractures, skin necrosis and infection.

Contractures require excision of the entire scar mass and replacement with improved skin either through flaps or full-thickness skin grafts. Free full-thickness grafts have limited application in the acutely traumatized hand but find a very useful application in replacement of scarred skin which must be excised as a separate elective procedure. A full-thickness graft may be taken from the groin or anticubital fossa. After the pattern has been made and mapped out over the area, the donor wound is converted in-

to an ellipse and closed by direct suturing without undermining the skin, by merely flexing the joint.

Traumatized Vascular Supply

Filleted skin may undergo necrosis if its vascular supply has been severely traumatized. This requires excision and skin grafting. If flexion contractures develop following these procedures, they may need to be released by Z-plasties. Each arm of the Z should be between 45 and 60 degrees. A more acute angle for the Z-plasty jeopardizes the points of the two flaps and allows only 25 per cent lengthening of the contracture line. Sixty-degree angles are preferred because blood supply is protected and the contracture lengthens as much as 75 per cent. An angle greater than 60 degrees makes mobilization of the flaps difficult if suturing is to be done with little tension on the skin margins.

Infection may result in a slough of all or a portion of any graft. These must be debrided as soon as possible, treated with continuous moist dressings, elevation, and immobilization to obtain a healthy recipient bed prior to definitive split thickness grafting. Pinch grafts have no useful application in the hand because they heal with lumpy, disfiguring scars.

During the post-operative period, as soon as satisfactory healing has occurred, active motion for the involved part is started. When joints are stiffened they may be assisted by small dynamic splints.

Conclusion

Thus, the problem of skin coverage varies in the traumatized hand from the very simple to the more complex procedures. Emphasis has been placed on primary closure, either by direct suture or by skin grafts. The skin graft may either be a free type of graft varying in its thickness, or flaps from either local or distant donor sites. With the careful selection of patients and the application of the methods described, a useful hand may be obtained, allowing the patient to return to a gainful occupation.

478 Peachtree St., N.E.

MASS IMMUNIZATION PROGRAM AIMED AT ERADICATING MEASLES

Beginning this month a mass immunization program aimed at eradicating measles in Georgia is being launched, according to Dr. John H. Venable, director of the Georgia Department of Public Health.

"The program has considerable potential," said Dr. Venable. "If it is successful at the local level, it will permit us to immunize practically all young children in the state."

"Under this mass program, which has the combined support of the Medical Association of Georgia, the Georgia Chapter of the American Academy of Pediatrics, and Georgia Jaycees, Incorporated, as well as the state Health Department, all children one year of age through second grade school children will be eligible for inoculation with measles vaccine. Children in grades three through seven who have not had measles nor been immunized may also be included at the discretion of the local community," the health director explained.

Teams of Vaccination Assistance Program personnel from the State Health Department together with local health professionals will administer the program and man vaccination stations in the community. Local Jaycee chapters will be responsible for acquainting parents with the significance of the program and with recruiting susceptible children.

GEORGIA HIGHWAY SLAUGHTER

Yearly Totals

1967 to date	1,452 Killed
1966	1,605 Killed
1965	1,354 Killed
1964	1,314 Killed
1963	1,278 Killed
1962	1,106 Killed
1961	1,017 Killed

Through November 1967
1,452 KILLED

Same Period 1966
1,435 KILLED

November 1967
131 KILLED

Economic Loss

1967 to date	$261,360,000
1966	288,900,000
1965	243,720,000
1964	236,520,000
1963	230,040,000
1962	199,080,000
1961	162,720,000

What's Happening

Seat belts are saving lives. However, safety experts say that traffic accidents annually take the lives of at least eight thousand people who might have lived had they been using seat belts at the time of the crash. These experts say that you are five times more likely to survive a crash if you are wearing seat belts. Do you like those odds? Even if you are not a gambler, you'll have to admit they are pretty good. Take advantage of the safety of a securely fastened seat belt. It is a good bet to save your life.

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Acetaminophen	325 mg.

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EDITORIALS

Leadership Conference Scheduled for February

THE TENTH ANNUAL OFFICERS LEADERSHIP CONFERENCE has been scheduled for Saturday and Sunday, February 3 and 4 at the Riviera Motor Hotel in Atlanta.

The 1968 edition brings together a potpourri of topics and ideas designed to broaden the knowledge of local county medical society officers on matters of current importance.

Included on the program is a discussion on what the medicare and medicaid programs are doing and the effects of these programs on the future practice of medicine; committee meetings; medical education; efficiency in medical practice; traffic safety; and the like.

On the lighter side, the Wits End Players will be featured in a return engagement immediately following the social hour sponsored by MAG.

The Annual Conference is staged for the benefit of county medical society officers and it is particularly important that each society be represented by at least one delegate in order that he may inform his society on the many activities of the State Association and allied groups. Please make your plans now to attend.

Edwin F. Smith To Be Executive Secretary

EDWIN FARWELL SMITH of Stone Mountain has been appointed Executive Secretary of the Medical Association of Georgia, to succeed Milton D. Kruager. Mr. Smith began January first.

Born in Richmond, Virginia, July 8, 1930, Mr. Smith attended public schools there, Bridgewater College, Bridgewater, Virginia, and was graduated from the Richmond Professional Institute of the College of William and Mary with a Bachelor of Science Degree in Business.

Mr. Smith was selected as Assistant Executive Secretary of The Medical Society of Virginia, January 1, 1954. In August 1965, he was picked by The American Medical Political Action Committee (AMPAC) to establish a Southeastern Regional office in Atlanta and to serve as Field Representative in the Region's seven states.

Active in Community

Mr. Smith was active in the Richmond Chapter of the Bridegwater College Alumni, serving as President in 1955. The Smith family are members of the Allgood Road Methodist Church where Mr. Smith has served on commissions and as a member of the choir. Before moving to the Atlanta area, Mr. Smith was

a member of the Board of Stewards and Secretary of the Official Board of the Boulevard Methodist Church, Richmond, Virginia.

As a disaster service volunteer with the American Red Cross, Mr. Smith has held the Advanced First Aid certificate and Water Safety Instructor certificate. Also active in the Richmond Y.M.C.A., Mr. Smith served on the Board of Management and as Chairman of Youth Program. In 1963 he was awarded the "Service To Boys" plaque for his youth work. Mr. Smith also holds a Life Membership in the Virginia Congress of Parents and Teachers which he was awarded in 1963.

Mr. Smith has long been active in the Boy Scouts of America and holds two Scouter's Key awards. He served as a leader in both the 1964 National Scout Jamboree and the 1967 World Scout Jamboree.

While at Bridgewater College, Mr. Smith met and married Ilene Virginia Neher of Midland, Virginia, and they have three children: Karen Marguerite, aged 16, John Edwin, aged 13, and James Walter, aged 8. Home for the Smiths is 4174 Rue Antoinette, Stone Mountain.

Progress in Exfoliative Cytology

In the late 1950's a great effort was made to promote exfoliative cytological studies in the State of Georgia. It was possible, although not without objection and opposition, for progress to be made which provides the basis for this report.

One of the few schools of cytotechnology in the United States (St. Joseph's Infirmary) was established in 1957. At this time there was one registered cytotechnologist in Georgia who had been trained by a cytologist in Augusta, Georgia. From this initial beginning with one cytotechnologist, a training program has provided sixty or more cytotechnologists. Later, a second school was established at Grady Memorial Hospital which has contributed to the total number of cytotechnologists trained.

The Georgia Division of the American Cancer Society and the Fulton County Division of the American Cancer Society have contributed significantly to the program in providing publicity and training funds. The most significant monetary contribution has been by the United States Public Health Service through training grants to schools of cytotechnology providing scholarships, aid for teaching personnel and the purchasing of equipment. As a result of these efforts we are now reaping some of the benefits of the era to which we are advancing—preventive and predictive medicine.

A nationwide survey in 1963 revealed that 15 per cent of all females, age twenty and over, had been cytologically examined: this was estimated to be 10 per cent in 1961. In 1963 the figure for Georgia was 29 per cent, ranking it first among all states in the continental United States. In 1966 a United States Public Health nationwide survey revealed 26 per cent of all females, age twenty and over, were estimated to have been examined by cytological studies.

The State of Georgia continues to rank first among the states with a rate of 43 per cent. This is an impressive figure and demonstrates what can be done toward preventing the development of a fatal disease. It also indicates the direction of medicine now and in the future—preventive and predictive. This should be the goal of medicine as we exploit for the benefit of our population the advances in laboratory medicine. Automated, computerized, multiphasic, preventive and predictive facilities are here and have set the pattern for medical practice in the future.

John T. Godwin, M.D.
Atlanta

Highlights of AMA Clinical Convention

The following summary of the activities of the AMA House of Delegates is given for the purpose of touching upon the more important items undertaken at the 1967 Clinical Convention in Houston, Texas. It is not intended as a detailed report of all the actions taken.

THE AMA HOUSE OF DELEGATES received and considered a large number of reports and resolutions at its 1967 Clinical Convention in Houston. The two final sessions of the House were attended by 238 of the 242 Delegates as 96 items of business were considered. These included 17 reports from the Board of Trustees; 20 from standing Committees of the House; special reports; and 57 resolutions.

Atlanta in 1972

In approving a report from the Board of Trustees, the House of Delegates voted to hold the AMA Clinical Convention in Atlanta on November 26-29, 1972.

Medical Education

Several actions were taken relating to medical education.

One was adoption of the Board of Trustees' summary of the Report of the Commission on Research. Fifteen recommendations were contained in the Commission report, two of which were seen as particularly significant.

(1) Encouraged research in the delivery of health care, "provided it is conducted under proper auspices and in accordance with sound research design and methodology." The House adopted it, with the understanding that such support "should not be interpreted to imply any criticism of the present studies of the delivery of health care." Present efforts are productive, but the medical profession "should not hesitate to make known its interest in continued studies to improve the methods and quality of health care delivery."

(2) Correcting the imbalance between biomedical research and education caused by the "heavy but desirable federal support of research." It stated that "there should be allotted a greatly increased amount for operational expenses of medical schools, to be matched by those schools through private or local government sources."

Again the House concurred, stressing the fact that its approval of the recommendation changes the policy of the AMA with respect to federal support for medical education. The change results in "an honest recognition that federal financial support is now accepted by the American medical schools." However, in adopting the recommendation, the House "emphatically urges that a matching formula be used" to "encourage medical schools to retain their independence."

The House also adopted a resolution that the AMA, through its Council on Medical Education, "utilize all appropriate influences to restore teaching to its proper place of prominence in medical education" instead of giving the lion's share of attention, honors and contributions to research scientists.

Hospital Medical Staff Guidelines

Also adopted under the general heading of medical education was the following resolution (the WHEREAS portion is omitted):

RESOLVED, That this House of Delegates of the American Medical Association recommend the following guidelines for medical staffs in hospitals with intern and resident training programs:

1. All physicians on the staffs of hospitals and/or medical schools which have formal training programs should cooperate with and participate in such training programs;
2. Any patient who is admitted to a hospital by his physician should remain under the care of that physician who will, in giving the care, with the

patient's knowledge and consent, cooperate as far as possible with the training program where such a program exists;

3. All patients who are admitted to a hospital and not referred by or requesting their private physicians should be assigned on an equal rotational basis to members of the medical staff;
4. For patients admitted by their physicians to teaching services in hospitals, fees should be collected for services rendered by those physicians of record as they are for their other private patients;
5. Hospital medical staffs or organizations representing the medical staff may bill for medical services rendered to patients on behalf of and only with the authorization of the attending physician rendering the care;
6. A hospital or medical school may not participate in the fees collected for medical services;
7. Fees for medical services collected by a hospital medical staff or organizations representing the medical staff should be distributed solely on the direction of the medical staff without coercion of any kind and in accordance with agreements previously reached by the physicians comprising the medical staff and the hospital or medical school;
8. All members of the medical staff who render services to these patients and for whom fees are collected by the medical staff or an organization representing the staff shall have equal voting rights in determining the distribution of the funds collected;
9. Full-time salaried physicians may participate in funds for services rendered to these patients in proportion to the percentage of their total salary ascribed to actual care of the patient;
10. Medical societies and hospital associations should engage in a combined program of education to insure a sufficient number of patients for the medical training programs of accredited hospitals;
11. If complaints of alleged coercion or of excessive charges for the collection of fees for medical services are received by local medical societies from any of their members, these societies should take appropriate action; and
12. Medical staffs entering into agreements for the collection of fees should seek appropriate advice concerning the legal and tax implications of such arrangements; and be it further

RESOLVED, That a copy of this resolution be sent to the American Hospital Association for its information.

Health Manpower

A report was adopted on the "Report of the National Advisory Commission on Health Manpower," which was submitted to President Johnson on November 20.

The report was necessarily brief, since there had not been time to study and evaluate the Commission report in any depth, but it pointed out that the Commission's approach to health care problems indicated recognition of the need for orderly procedures rather than harmful "crash" programs. The emphasis in most of the Commission report is to center responsibility on the professional groups best able to evaluate and plan in health areas, rather than on government and non-professionals.

The House adopted the preliminary report; voted to enlarge the AMA Committee on Health Manpower by four members to permit more careful and complete study in this area; and noted that copies of the complete Commission report will be sent to all Delegates and Alternates, requesting them to submit their comments to their constituent associations as soon as possible.

Medicare and Medicaid

In regard to medicare, the House reaffirmed its support for direct billing under

the federal program and adopted a resolution regarding the collection and public dissemination of figures on the administrative costs of medicare.

The House resolved that the AMA continue its efforts to provide for the implementation of Title 19 in a manner which recognizes "the physician's right to bill directly all patients, including Title 19 patients, and allows the physician or his patient to be reimbursed his usual, customary and reasonable fee for his professional services"; and that the Association actively seek changes in the law that will secure "equal and simultaneous application to all jurisdictions."

Hospitals

Because both medicare and medicaid provide payment for medical care rendered to patients by residents, the House resolved that the Association should study the problem and develop guidelines that are acceptable to supervising physicians, teaching institutions and government agencies involved in the payment process.

In addition, with respect to hospitals, the House adopted resolutions:

Proposing the acceptance of physicians on hospital Boards of Trustees as the most effective form of liaison between the medical staff and hospital governing authorities.

Protecting hospital privileges through "due process."

Calling for more effective liaison and better coordination between medical staffs and local medical societies.

Pointing out the need for simplifying attendance requirements for maintaining membership on hospital medical staffs.

Pressing for prompt revision of the JCAH ruling on the use of externs in non-university affiliated hospitals, with the incorporation of adequate safeguards to insure the quality of programs of extern education.

In addition, model articles of incorporation for hospital medical staffs were made available for distribution in response to requests.

MANUAL ON ALCOHOLISM PUBLISHED BY AMA

A new Manual on Alcoholism, published by the American Medical Association, comes at a time when practical medical guidelines are needed in dealing with this problem.

In 87 pages, the AMA's new manual defines alcoholism and sets out its causes. It describes the metabolism and pharmacology of alcohol, and offers suggestions on diagnosis and the physical, psychological, and sociological aspects of treatment.

In plain language, it tells what an alcoholic is and is not, and what physicians can do to help him.

Basic general information is presented in the text, and more specific considerations are outlined in an appendix. The appendix sections include: (1) "Clues" to aid in the diagnosis of alcoholism, (2) General considerations in managing the hospitalized alcoholic, (3) Immediate considerations when the alcoholic patient enters the hospital, and (4) Alcohol blood levels and intoxication.

Thirteen authorities submitted resource information for the manual. This material was edited and a final manuscript written by Robert J. Shearer, M.D., former associate director of the AMA Department of Mental Health.

The manual is available from the Order Handling Unit, American Medical Association, 535 N. Dearborn St., Chicago, Illinois 60610. Prices are 50 cents a copy in the U.S., its possessions, Mexico, and Canada (40 cents a copy for medical students, interns and residents in those countries), and 60 cents in all other countries.

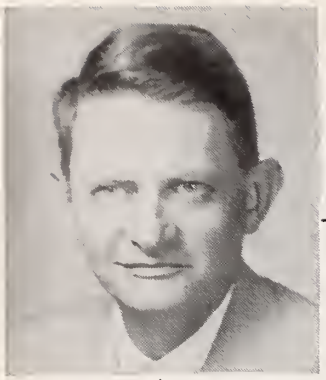
CALL FOR SCIENTIFIC EXHIBITS

114TH ANNUAL SESSION OF THE MEDICAL ASSOCIATION OF GEORGIA

Augusta, Georgia, May 5-7, 1968

For Information and Applications, Write to:

John McClure, Jr., M.D., Chairman, MAG Scientific Exhibits Committee
938 Peachtree Street, N.E. • Atlanta, Georgia 30309



DON'T MOVE ME . . .

(. . . Unless You're Trained in Highway First Aid)

At the Recent Annual Rural Health Conference held at the Rock Eagle 4-H Center, a Red Cross worker speaking relative to emergency medical services, particularly in regard to highway traffic accidents, said, "Should any of you sitting here ever see me involved in a highway traffic accident, I would hope that you allow only those having first aid training to move me."

This statement may seem a little strange on the surface, but closer analysis reveals the fact that a very large percentage of Georgia's ambulance drivers double as service station attendants, routemen, clerks and the like and have next to no training in first aid and may do more harm than good in moving a highway traffic victim.

Two of MAG's Committees—Traffic Safety and Rural Health—have begun working toward alleviating this condition. These two Committees, in cooperation with the American National Red Cross, plan a state-wide drive directed to county medical societies seeking assistance in encouraging the establishment of Highway First Aid Training Programs in their county.

The program works like this. The local Chapter of the American National Red Cross will offer instruction on First Aid if there is sufficient interest. This program consists of two courses—basic and advanced. The whole idea is to train laymen on how to act and react at the scene of a highway accident. This course is particularly good for an area where the local policemen, firemen, ambulance drivers and the like have had no training in moving injured persons.

The objectives of this program are pointed out in a Red Cross publication entitled *First Aid on the Highways:* "(1) To provide trained first aid assistance—and it should be clearly established that Red Cross first aid does not take the place of medical aid—to persons injured on the highways; and (2) to help reduce traffic accidents."

Hopefully, anyone completing the advanced course will apply for certification as a mobile unit operator who will be obliged to render highway first aid should he come upon an accident while traveling. Also, there are provisions for fixed first aid stations along state highways.

Our two Committees should be commended for taking the initiative in promoting such a worthwhile project. One only has to read the daily statistics of Georgia highway accidents to realize the significance of this effort. Help your locality become better prepared to cope with the situation by insisting that your Red Cross Chapter offer highway first aid instruction to your citizenry.

John T. Mauldin, M.D.
President, Medical Association of Georgia

AMERICAN CANCER SOCIETY SERVICES TO PATIENTS

J. BENHAM STEWART, *Atlanta*

PROGRESS AGAINST CANCER has been made and yet cancer remains one of our most serious health problems. Between 1960 and 1965, in Georgia alone, cancer killed 28,516. Estimates are that there will be 10,000 NEW cases in Georgia this year.

Many cancer cases under treatment will fall into the "medically indigent"* classification. The families of these patients will need assistance in meeting the financial demands placed on them. It, therefore, would behoove the medical profession to become informed on the community resources available to these patients and their families.

The American Cancer Society is one agency offering help to cancer patients. The following is a brief outline of the services offered indigent and medically indigent patients in Georgia, as specified by the Georgia Division Volunteer Patient Service Committee, Dr. Gray Fountain, Albany, Georgia, Chairman.

Patient Transportation

Under this program the Society enlists volunteers to transport patients to and from clinics, doctors' offices, hospitals, and for diagnosis and treatment. When volunteer transportation is not available or does not meet the need of the patient, the Society may pay a limited amount to ambulance or other carriers.

Gift and Loan Service

The Society provides for patients items such as bandages and innumerable other gift items, most of which are made by volunteers. In addition, items such as hospital beds, wheel chairs and other sick room conveniences are loaned to patients.

Pain-Relieving Drugs

The Unit Volunteer Patient Service Chairman is authorized to make limited payments to cooperating druggists to fill prescriptions issued by licensed physicians for the following drugs:

Morphine	Phenaphen with Codeine
Codeine	Tincture of Opium
Darvon	Demerol
Empirin Compound with Codeine	Percodan

Leukemia Service

The Society authorizes the payment to participating druggists for prescriptions issued by a licensed physician for the following chemotherapeutic drugs when purchase of these drugs would cause a hardship on the family of patients with

acute leukemia, chronic leukemia, Hodgkin's Disease, lymphoma, myeloma, or choriocarcinoma:

Oncovin	Velblan (Velblastin)	Vincristine
Prednisone	Methotrexate	Cytoxan
Alkeran	Chlorambucil	
6-Mercaptopurine	Myleran	

Home Visiting Service

Some units of the Society provide, with the approval of the attending physician and under his direct supervision, trained home visitors. Where this program has been adopted, these persons are carefully selected and are trained by physicians and nurses to provide: (1) Relief of the patient's family of the care of the patient at intervals so that the family members may have some relief from confining responsibility; (2) assistance to the family in learning how to care for the patient; and (3) some recreational outlet for the patient through craft activities, reading, etc.

The local unit of the American Cancer Society will be glad to help with any problem involving the welfare and comfort of a cancer patient.

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* *Medically indigent patients are those who are not able to pay for necessary medical care but do not quality for governmental medical care.*

HIGHLIGHTS OF THE MAG EXECUTIVE COMMITTEE OF COUNCIL MEETING, NOVEMBER 19, 1967–ATLANTA

This summary is being published so that the MAG membership may be advised in brief of the actions of the Association's Council and Executive Committee. It covers only major actions and is not intended as a detailed report. Full minutes of these meetings are available upon any member's request to the MAG Headquarters Office.

Nominations and Appointments approved by Executive Committee included the following three names for the Governor's consideration to fill the vacancy, due to the resignation of Dr. Julian Quattlebaum, Jr., Savannah, for the post of 1st District State Board of Health member: Thomas R. Freeman, Savannah; J. C. Metts, Jr., Savannah; and L. H. Griffin, Claxton—as submitted to MAG by the 1st District Medical Society. Dr. M. C. Adair, Washington, was named Chairman of the MAG Medical Ethics Committee and Dr. Lillian Warnick was appointed to the MAG Maternal and Infant Welfare Committee. Dr. J. Gordon Barrow, Atlanta, was named to an MAG Ad Hoc Committee to study P.L. 89-749—Comprehensive Health Care Planning, which has been designated for State Department of Health implementation.

Medical Assistance Programs (Medicaid) hospital claims review, which was formerly performed by contract by MAG with State Department of Family and Children's Services—was approved for continuation by contract with the State Department of Health. MAG employees serving under this new contract will be headquartered at the Department of Health working under the supervision of MAG.

Vocational Rehabilitation Program plans for physician reimbursement on the basis of usual, customary and prevailing fees as determined by the insurance carrier for Medicaid (Travelers Insurance Company) was approved by Executive Committee. The MAG Medical Review and Negotiation Committee recommended this approval and further offered the services of the Committee and the MAG Medical Review Committees to the Travelers Insurance Company on the same basis as MAG liaison with the Medicare insurance carrier (John Hancock Insurance Company).

MAG 1968 Budget, as prepared by the MAG Committee on Finance meeting jointly with MAG Executive Committee, was approved for recommendation to MAG Council. The Council will consider this proposed 1968 MAG Budget at their forthcoming meeting on December 9-10, 1967 at Valdosta, Georgia.

Third-party Payments to Physicians in Teaching Institutions was reported on by President John T. Mauldin. Council had previously appointed a study committee on this matter. Dr. Mauldin described the three meetings already held by this Committee and Executive Committee received this progress report for information at this time.

Measles Immunization Program on a state-wide basis as presented by the State Department of Health was approved by Executive Committee. This program is a "first" in the country and merits full physician cooperation.

MANAGEMENT OF ATRIAL FIBRILLATION

GEORGE R. MAYFIELD, M.D., *Augusta*

ATRIAL FIBRILLATION is the most common chronic atrial arrhythmia. It occurs most often in ischemic heart disease, rheumatic mitral disease, and thyrotoxic heart disease, but is also seen in the primary myocardoses. The underlying abnormality is either ischemia of the atrial muscle (diffuse fibrosis) or atrial dilatation and hypertrophy.

It has been demonstrated that myocardial efficiency is reduced 20 to 30 per cent during atrial fibrillation by loss of the "topping off" function of atrial contraction, which normally fills the ventricle more completely and increases the force of ventricular contraction. In otherwise normal hearts the arrhythmia is well tolerated, but in diseased hearts failure is exaggerated and angina accentuated. Pulmonary edema may be precipitated in the presence of mitral stenosis.

Digitalization Reduces Response

Untreated atrial fibrillation normally leads to an irregular ventricular rate of 110-180 beats per minute. The *primary* concern is to reduce the rate of ventricular response. This is done by digitalization, most often orally, though sometimes urgency requires parenteral digitalis. The ventricular rate is slowed to 70-80 per minute with complete digitalization in the great majority of cases; and digitalis alone may produce reversion to normal rhythm, especially in those with mild disease, and when the fibrillation is of short duration (weeks). If atrial fibrillation persists after adequate digitalization, one must decide whether to attempt reversion of the rhythm to normal with quinidine or electrical conversion.

Quinidine is successful from 50 to 80 per cent of the time, but is least helpful and relatively more dangerous in the sicker patients in whom reversion is most critical. Quinidine has other drawbacks:

1. It is toxic, producing depression of electrical and mechanical properties of the heart, and may lead to shock and ventricular fibrillation.
2. It will cause cinchonism with nausea, vomiting and diarrhea at unpredictable dosage levels.
3. The effect on reversion is inconstant and may occur in hours, days, or never.

Electrical Therapy

Electric conversion by a D-C defibrillator carries little risk even in seriously ill patients, such as those with recent infarctions. It has a 95 per cent effectiveness in converting the rhythm, though the chance of *maintaining* the reversion is no greater than with quinidine. Either method, drug or electrical, requires maintenance quinidine dosage to prevent recurrence. A cardinal rule against electrical therapy is a patient's inability to tolerate quinidine in a dose of at least 0.2 gram every 6 hours. This quinidine dosage is begun 48 hours before reversion to assess tolerance, and also to identify the 10 per cent or so of patients who will convert on such dosage.

Many clinicians discontinue digitalis for 24 to 48 hours before electrical conversion. In the presence of atrial fibrillation large doses of digitalis can be tolerated, but after reversion evidence of digitalis toxicity often appears. Electrical conversion is contraindicated when an arrhythmia is produced by digitalis toxicity.

Conditions Requiring Conversion

The situations calling for conversion are (after Hurst):

1. Patients without underlying heart disease.
2. The presence of congestive failure not well controlled by ordinary means.
3. Emboli that are thought to originate in the atria.
4. Hyperthyroid patients in whom fibrillation persists after euthyroid status is achieved.

Those who should *not* be converted include:

1. Patients who cannot tolerate quinidine in doses of 0.8 to 1.2 grams daily.
2. Those who have been reverted several times by any method, only to relapse while on quinidine prophylaxis.
3. Those with complete heart block.
4. Perhaps those whose fibrillation is of 5 years known duration (though some might still be candidates).

Relative contraindications would be:

1. Elderly patients doing well on digitalis.
2. Those who will soon have cardiac surgery.
3. Those who have very slow ventricular rates *without* digitalis.
4. Patients with ventricular conduction defects (BBB) should have electrical conversion, not quinidine.

In past years, elaborate quinidine schedules have been put forward. It would now seem that doses greater than 0.4 gram quinidine every 2 hours for 5 doses (total of 2 grams in 24 hours) should be avoided and the patient transferred to a center for electrical conversion if it is not locally available. This presence of a team with monitoring devices available at the moment of conversion should eliminate the unexpected deaths that occur during relocation of the pacemaker of the heart, and emboli can be sought and treated if they occur (1 to 2 per cent).

1713-B Central Avenue

BACTERIAL MENINGITIS FILM OFFERED BY AYERST

Ayerst Laboratories, distributors for Beecham Research Laboratories, is making available to the medical profession a unique new medical film—*Bacterial Meningitis.*

The film, in color and sound (running time—25 minutes), is narrated by Paul H. Wehrle, M.D., Hastings Professor of Pediatrics, University of Southern California Medical School, and Chief Physician, Pediatric and Communicable Disease Services, Los Angeles County General Hospital. Dr. Wehrle discusses concepts in the differential diagnosis and techniques of treatment of bacterial meningitis, as well as complications associated with the disease. Methods of treatment, including various forms of drug therapy, are considered. The disease is examined from the viewpoint of the problems faced by the practicing physician. This film will form the basis for an informative and provocative program on the diagnostic and therapeutic aspects of bacterial meningitis.

In addition to *Bacterial Meningitis,* two other exceptional films on infectious disease are presently available from Ayerst Laboratories: *Chronic Bronchitis—A Team Affair* (color, sound, running time—30 minutes) and *Reprieve from Lethal Infection* (color, sound, running time—18 minutes).

To receive any or all of these films, contact Beecham Research Laboratories, Inc., 685 Third Avenue, New York, N.Y. 10017.

HOME CARE SERVICES INFORMATION AVAILABLE

A kit of informational materials on home care services, specifically designed for the practicing physician has recently been prepared by the Home Health and Related Services Branch, U.S. Public Health Service. Community groups, medical societies and other professional associations who will assume responsibility for distribution to local doctors and for reporting usefulness of the material may be supplied kits in bulk. A sample copy of *The Physician and Home Care Services* is available, for review, from the Home Care Training Center, The Jewish Hospital of St. Louis, 216 S. Kingshighway, St. Louis, Mo. 63110, or from the Department of Health Care Services, American Medical Association.

WRITTEN CONSENT—A TRAP FOR THE UNWARY

JOHN K. TRAIN, III, *Atlanta*

PHYSICIANS ARE KEENLY AWARE that the relationship between physician and patient is a consensual one, and that the physician who undertakes to treat a patient without express or implied consent may find himself the object of a suit for assault and battery. The careful physician will, therefore, explain his proposed treatment to the patient in detail, especially when the treatment involves radical surgery. In order to be doubly sure, consent to any particular course of treatment or surgery should be obtained in writing from the patient. However, the mere fact that written consent has been obtained from a patient for the treatment or operation contemplated does not forever protect the physician. This consent, like spoken or implied acquiescence by the patient, may be withdrawn by him. (The subject of withdrawal, and the requirements for establishing the withdrawal of consent, have previously been discussed on the Legal Page of the January 1965 issue of the *Journal of The Medical Association of Georgia* at page 25.) A physician who obtains a patient's written consent to an operation should make certain that the written consent describes accurately the treatment to be administered, and that the patient understands what this treatment involves. The physician should also realize that merely by obtaining written consent to treatment, he is not thereafter protected should the patient withdraw consent.

These lessons are brought home in a California case.

Facts of Case

The plaintiff, a lady, testified that the defendant physician had told her that certain findings indicated she might have cancer of the breast. According to the plaintiff, the physician then told her that she should go into the hospital to have a test of "a lump under my breast" to determine whether or not cancer was present.

Upon completion of the examination, the physician told her that he would contact the hospital to make sure that there was space available for her. The plaintiff said that she then overheard the physician ordering a tray "for the removal of a right breast." At this point, the plaintiff said, she very forcefully told the physician that he was "not going to remove it." Subsequently, the plaintiff entered the hospital, at which time she signed a standard consent form in which she extended consent to the physician (who was named in the form) "to perform an operation for mastectomy . . . and to do whatever may be deemed necessary in his judgment." After she had gone to her room, on the evening before her operation, the plaintiff asked the physician again about the treatment she was to receive, stating that she wanted to be sure that he understood that he was not to remove her breast. According to the plaintiff, the physician responded once again that he was simply going to make a test and had no intention of removing her breast. Thereafter, the physician did in fact perform a mastectomy, testifying that his examination of the plaintiff's breast indicated the presence of cancer there and that he felt the only way to prevent its spread was to perform the mastectomy.

Upon discovering at a later date that she had not in fact had cancer, the plaintiff brought suit against the physician for assault and battery (and for negligence in failing to have a biopsy made prior to the mastectomy). The lower court judge directed a verdict in favor of the physician on the issue of consent, on the basis of the written document.

Court's Holding

The court distinguished between the attempt on the part of a patient to *repudiate* consent freely given and the patient's specific *withdrawal* of con-

Prepared at the request of The Medical Association of Georgia. Mr. Train is an associate in the firm of Alston, Miller & Gaines, General Counsel to The Medical Association of Georgia.

sent. (This naturally would be important insofar as the physician's treatment between the time consent was given and the time of withdrawal is concerned, for if the patient could *repudiate* consent completely, there would have been no consent to anything the physician had done.) The court went on to point out that the general consent, even though in writing, which had been given by this patient could have been found by a jury to have been withdrawn by the patient after she was admitted to the hospital. The court ruled that the patient's supposed statements to the physician on the evening prior to the operation, in which she made clear that she anticipated nothing other than a test of the breast, and specifically expressed her opposition to a removal of it, should have been submitted to a jury in order that the jury might determine whether or not this was a sufficient expression of withdrawal of consent. Given that further examination revealed that the plaintiff did not have cancer, it is reasonable to assume that the jury might well have found in the plaintiff's favor.

Comment

The above case makes the very cogent point that no consent, written or spoken, is binding forever, and may be withdrawn by the patient at any time (if it is medically feasible for the physician to stop the treatment without danger to the patient's health or life). The withdrawal may come about not only in express terms ("Doctor, I have decided that I don't want to have the operation which you have described to me"), but may also be implied from the comments of the patient ("Doctor, I would certainly never want to have my breast removed"). The physician must be alert at all times to see that the patient understands the particular treatment to be given and that nothing which the patient has said can be later construed as a renunciation of general consent previously given.

Also involved in the question of consent and its withdrawal is the question of the extent of consent clearly given. The above case raises this issue, though it does not discuss it at any length. It was contended by the patient that she had no idea of what a "mastectomy" was, and thus was not bound by the form of consent which she executed. Generally speaking, it is true that a person is bound by a document in writing according to that document's terms, and may not vary those terms later absent some showing of fraud. In this situation, there might have been fraud present had there been an affirmative statement by the physician that he was not going to perform an operation involving removal of the breast, in order to induce the woman to sign the consent to a mastectomy. However, the courts are very conscious of a person's right to a full explanation of almost any medical treatment. It is clear that a physician who does not fully explain treatment to a person before proceeding runs a tremendous risk, if the patient can make a good case of having been ignorant of that to which he consented. Again, the lesson is that "general consent," though acceptable when giving a routine physical examination, is not sufficient when surgery or other such treatment is involved. The physician should be certain that the patient is fully aware of the nature of the treatment and should also maintain some record to show both the fact that the patient was informed and that, being informed, he consented to the treatment.

Finally, the physician should be alert at all times to action by a patient which would constitute a withdrawal of consent previously given.*

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* *The case discussed is Corn v. French, 289 P.2d 173 (1955).*

Suite 1220
C & S Bank Building

"MD" CAR BUMPER STICKERS AVAILABLE TO GEORGIA DOCTORS

The green and white, reflective "MD" stickers, which a physician may attach to his car bumper, are once again available from the Medical Association of Georgia. Complete with the seal of the Medical Association and the admonition to "Drive Safely," the stickers may be obtained, free of charge, by writing to: *Medical Association of Georgia, 938 Peachtree St., N.E., Atlanta, Ga. 30309.*

EMORY STUDENTS WIN RESEARCH AWARDS

David E. Woodruff, Jr., of Atlanta, a senior in Emory University School of Medicine, won first prize in the school's thirteenth annual Student Research Day. Mr. Woodruff discussed a research project concerning multiple sclerosis, a disease of the nervous system.

His project was sponsored by Dr. Robert F. Kibler, associate professor of medicine (neurology), Emory University School of Medicine.

The first prize, awarded on the quality and presentation of the research project, consisted of $150. The second prize of $50 went to R. Robert Eastridge, Jr., of Coral Gables, Fla. Mr. Eastridge is also a senior.

The prizes, known as Upjohn Achievement Awards, are provided by the Upjohn Company.

MENTAL HEALTH COMMITTEE

THE COMMITTEE ON MENTAL HEALTH is planning to be active during the coming year. At the last meeting held in December, the following statement of purposes and goals under which the Committee will function was approved:

> "To act in an advisory capacity to the Medical Association of Georgia in matters pertaining to mental health and mental illness, and to attempt to keep the Medical Association of Georgia informed as to relevant developments in this area.
>
> "To provide leadership in the field of mental health and mental illness in promoting better patient care, and in the prevention of mental disorders.
>
> "To act in a capacity for stimulating interest and further informing both the Medical Association of Georgia members and, to a lesser extent, lay individuals concerning mental health and mental illness."

Physician Education Is Concern

The Committee is vitally concerned with physician education in mental health and mental illness matters and plans to survey each county medical society concerning their extent of involvement in psychiatric problems and mental health activities. The Committee is hopeful that the survey will stimulate more interest which will result in a better understanding on the part of the local physician of the psychiatric problems in the state.

It is the feeling of the Committee that the Medical Association of Georgia, Georgia Psychiatric Association, and the Division of Mental Health of the Georgia Department of Public Health must be closely allied in promoting the state mental health efforts in the private and public sectors. The next meeting of the Committee will be devoted to a large degree to establishing better liaison between these groups as well as all disciplines concerned with mental health and mental illness.

Expansion of Facilities

The Committee has a keen interest in the improvement and expansion of psychiatric treatment facilities in both the public and private sectors. In the sector of public treatment facilities, the Committee takes interest in the decentralization of patients at Central State Hospital by transfer to Thomasville and Bainbridge and has supported a resolution which has been approved by Council calling for quickest possible construction of the Mental Retardation Institute and the regional mental hospitals in Atlanta and Augusta which would also help reduce the overcrowded conditions at Milledgeville.

The Committee solicits comments and suggestions from county medical societies as well as individual physicians concerning its activities.

Julius T. Johnson, M.D.
1445 Harper Street
Augusta

NEW MEMBERS

Cleveland, John Q., Jr.	1364 Clifton Road, N.E.
DE-2—Fulton	Atlanta, Georgia 30322
Delashmutt, Robert E.	300 Boulevard, N.E.
Active—Fulton	Atlanta, Georgia 30312
Elson, Eileen F.	183 Harris Street, N.E.
Active—Fulton	Atlanta, Georgia 30303
Landy, Michael S.	P. O. Box 29457
Service—Fulton	Atlanta, Georgia 30329

SOCIETIES

The Third District Medical Society and **Woman's Auxiliary** met in Montezuma October 26 for their semi-annual meeting. Henry Boyter of Columbus was installed as president to succeed R. A. Collins of Americus and A. J. Morris of Montezuma was named president-elect.

Lamar Pilcher of Warner Robins, Wentford A. Spears of Warner Robins, and Tom Ross of Macon presented the clinical program.

The Woman's Auxiliary meeting was presided over by Mrs. A. J. Morris of Montezuma. Mrs. Frank Wilson of Leslie presented a talk on the "Doctor's Wife" rose and Mrs. James H. Manning of Marietta, state president of the Woman's Auxiliary, spoke on the year's theme, "Unlimited Dimensions." Mrs. W. B. Willingham of Macon spoke on the fabrics used in the decoration of the White House.

The Richmond County Medical Society joined with the Diabetes Association of Augusta in November in an attempt to find hidden diabetes in the local population. Alex T. Murphey, chairman of the Diabetes Detection Drive, explained that a kit enabling people to take a test for diabetes at home was made available through local drugstores.

The Woman's Auxiliary to the Bibb County Medical Society heard Dr. A. L. Lawrence, Jr., speak on "Macon's Recreation Program" at their November meeting.

PERSONALS

First District

Curtis Hames of Claxton was honored October 31 at a dinner given by Mr. and Mrs. Harry Smith. Dr. Hames described many interesting incidents of his recent trip behind the Iron Curtain to address a medical meeting in Poland.

Third District

Harry Brill of Columbus spoke to the East Columbus Rotary Club in October on the dangers of smoking.

Franklin Dozier Edwards of Columbus has been installed as new president of the Georgia Urological Association.

Fourth District

Joel E. Mikell has begun medical practice specializing in radiology at Upson County Hospital in association with **Hubert F. Anthony, Jr.**

A. S. Fitzhugh of Griffin has returned from two months' volunteer service in South Viet Nam. His observations on medicine there were reported in the *Griffin Daily News Magazine* in October.

Fifth District

Amey Chappell of Atlanta was awarded the Elizabeth Blackwell Medal by the American Medical Women's Association during the Association's annual meeting held in Atlanta in early December. This is the highest award bestowed upon a member by the Association and was given for "Beloved Teacher, Civic Leader and Loyal Leader of the Association."

Osler A. Abbott, professor of thoracic surgery at Emory University School of Medicine, has been elected president-elect of the Southern Thoracic Surgical Association. He will be installed as president during the fall meeting in San Juan, Puerto Rico. Dr. Abbott was also recently elected a Regent of the American College of Chest Physicians.

An article in the *Sandy Springs Enterprise* featured **Lea Richmond** of Sandy Springs. Dr. Richmond's interests and hobbies were described and his dedication to his community noted.

Mason I. Lowance of Atlanta was elected vice-president of the American Association for Clinical Immunology and Allergy during the annual meeting in Las Vegas in November at which he presented a paper dealing with the individual rights of the clinician.

Gabriel S. Zatlin of Atlanta and **Elma Mera Steves** of Chamblee have been elected to fellowship in the American Academy of Pediatrics.

Sidney Olansky of Atlanta was chairman of the Dermatology Section of the Southern Medical Association meeting held in Miami in November. Dr. Olansky also presented a paper on a double blind study of Azouridine in the treatment of Psoriasis.

Sixth District

An article in the *Macon Telegraph* featured **W. O. (Spike) Williams** and **Raymond Moody** of Macon, who are promoting running as one of the best ways to remain healthy and reduce chances of heart attack.

Seventh District

Dr. and Mrs. Jack Tanner entertained in November for **Dr. and Mrs. Jim McGuire.** Dr. McGuire has recently become associated with Dr. Tanner in the practice of gynecology and obstetrics in Marietta.

W. Glenn Petty of Chattanooga, Tennessee, has opened offices for the practice of general surgery in Chattanooga.

Marietta general surgeon **Charles R. Underwood** was named "Boss of the Year" by the Marietta Charter Chapter of the American Business Women's Association.

Eighth District

Jose Martinez of Waycross has successfully completed the examinations of the American Board of Anesthesiology.

Ninth District

Bruce Schaefer of Toccoa has received a certificate for distinguished and honorable service on the State Medical Education Board.

Tenth District

Sterling A. Harris of Buford, **Harold G. Long** of Dahlonega, **William Nicholson** of Hiawassee, **John N. Shearhouse** of Lavonia, **Richard J. Turner** of Clayton and **James B. Wilbanks** of Clarkesville have been honored for their participation in the Georgia Country Doctor Program.

J. Hubert Milford of Hartwell and **John N. Shearhouse** of Lavonia have received certificates for distinguished and honorable service on the State Medical Education Board.

Robert Eugene Tanner of Augusta has been elected to fellowship in the American Academy of Pediatrics.

Victor Moore of Augusta has been named director of medical education and research at University Hospital in Augusta.

DEATHS

J. Emory Clay

J. Emory Clay, long-time Macon physician, died October 23, 1967, at his home in Macon.

Dr. Clay was born in Bibb County in 1901. He was graduated from Auburn University and the University of Tennessee Medical College. He was engaged in medical practice from 1925 until his retirement in 1961.

Dr. Clay was a member of the Bibb County Medical Society, the Medical Association of Georgia and the American Medical Association. He was also a member of the Macon Masonic Lodge No. 5.

Survivors include his widow, the former Lena Coates; three sons, J. Emory Clay, Jr., George M. Clay and Charles Lloyd Clay; one brother, Calder B. Clay, Sr.; one sister, Mrs. Lillie Heath, and a number of nieces and nephews, all of Macon.

Ralph W. Fowler, Sr.

Ralph W. Fowler, Sr., 69, of Marietta died October 30, 1967, at Kennestone Hospital following an extended illness.

A native of Cobb County, Dr. Fowler graduated from the University of Georgia and Emory University School of Medicine. Dr. Fowler was one of the founders of the old Marietta Hospital. Later, when Kennestone Hospital replaced the old hospital, he served as a member of the Marietta Hospital Authority and later as its chairman. He was former chief of the pediatrics staff at Kennestone Hospital.

Dr. Fowler was a charter member of the Cobb County Medical Society and one of its past presidents, and also served as Seventh District Councilor to the Medical Association of Georgia.

Dr. Fowler served Marietta as a member of the Board of Education and the Board of Lights and Water. He was a charter member and first president of the Marietta Kiwanis Club, and a member of the First Baptist Church.

Dr. Fowler is survived by his wife, the former Jewell Antley; two daughters, Mrs. Lamar Glenn of Athens and Mrs. Charles Cox of Marietta; three sons, Dr. Ralph W. Fowler, Jr., of Marietta, Robert D. Fowler of Lawrenceville and John W. Fowler of Marietta; and his sister, Miss Sallie Fowler of Marietta.

Victoria Irene Johnston

Victoria Irene Johnston, 70, widow of Dr. T. H. Johnston, died November 12, 1967, in the Brunswick Hospital.

Dr. Johnston was born in Canada and was a graduate of the Manitoba Medical School in Winnipeg, Manitoba, Canada. She moved to Douglas, Georgia, in 1927, then moved to Brunswick about twenty years ago.

Dr. Johnston was a member of the Glynn County Medical Society as well as the Woman's Medical Auxiliary, the Medical Association of Georgia and the American Medical Association. She was also a member of St. Mark's Episcopal Church in Brunswick. Survivors are a daughter, Miss Joyce A. Johnston of Brunswick, and several nieces and nephews living in Canada.

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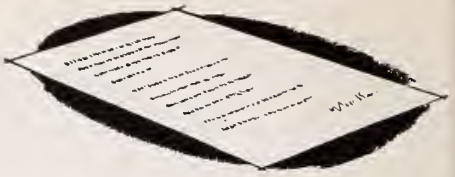
ABSTRACTS BY GEORGIA AUTHORS



Logan, Wm. D., Jr., M.D., Hatcher, Charles R., Jr., M.D., Symbas, Panagiotis N., M.D. and Abbott, Osler A., M.D., Emory Univ. School of Medicine, Atlanta, Ga., "Additional Consideration in Pulmonary Embolectomy," Am. Surgeon 33:706-710(Sept.) 1967.

A report of the experience with pulmonary embolectomies is reported. This includes nine (9) cases of arteriotomy for embolectomy and one (1) pneumonectomy for a chronic obstructive lesion.

According to varying reports most cases of pulmonary embolism are missed clinically and the usual and unusual features are stressed to reiterate the number of missed or non-diagnosed cases. Pulmonary angiograms and lung scans have been the two most widely used studies that have added to our clinical findings. At present, pulmonary angiogram seems to be superior to the pulmonary scan. Pulmonary angiograms can be done on the operating table with a portable machine and were used in two of these cases with some beneficial information.

Some cases of pulmonary emboli are unilateral and embolectomy may be done without using extracorporeal circulation. Three (3) of the nine (9) cases reported here were done using this technique. There were also three (3) cases of chronic pulmonary embolism, which points out the problems that may develop when these clots do not lyse early. Most patients with pulmonary emboli seem to show rapid lysis of the embolus with complete clearing and return to a normal pulmonary vascular bed in a matter of a few weeks. All factors in the clearing of remaining chronic emboli are not fully understood and additional work must be done in this area.

Two (2) cases were mis-diagnosed and did not have pulmonary emboli. Of the six (6) patients with massive embolism, four (4) survived.

Lindsay, Joseph, Jr., M.D., Emory Univ. School of Medicine, Atlanta, Ga., "Pulmonary Edema Following Cardioversion," Am. Heart Journal 74:434-435(Sept.)1967.

A case is reported of a man with rheumatic heart disease and mitral regurgitation who developed pulmonary edema following electrical conversion of his atrial fibrillation to normal sinus rhythm. The patient ultimately died from this problem. No inciting cause was detected at autopsy.

It is the purpose of this report to call attention to the unusual phenomenon of postcardioversion pulmonary edema. The mechanism is unknown. Some British writers have postulated direct damage to the myocardium by the electrical shock. Others have thought that restoration of the booster pumping action of the right atrium but not of the left might result in the rise of mean left atrial pressure above the critical level for pulmonary edema.

Mahesh, V. B., Ph.D.; McDonough, P. G., M.D., and Greenblatt, Robert B., M.D., Medical College of Georgia, Augusta, Ga., "Endocrine Studies in a Patient with Virilism, Ovarian Stromal Hyperplasia and Endometrial Carcinoma," Obstetrics and Gynecology 30:584-590(October)1967.

A patient with marked hirsutism, alopecia, and menstrual irregularities was studied on several occasions. Histologic studies following hysterectomy and bilateral salpingo-oophorectomy revealed ovarian stromal hyperplasia and endometrial carcinoma in situ or marked adenomatous hyperplasia. Urinary steroid studies four years prior to operation indicated excessive ovarian steroid secretion. Studies immediately prior to and after operation indicated that the ovarian stroma was relatively inactive in steroid secretion.

The study is another addition to the few hormonally oriented case reports in the literature concerning patients with virilism, stromal hyperplasia of the ovary, and endometrial hyperplasia or carcinoma. Many more data are needed before any relevancy can be established.

Schubert, Joseph H., and Brasher, Charles A., National Communicable Disease Center, Atlanta, Ga., "An Appraisal of Serologic Tests for Tuberculosis Using Agar Gel and Complement-Fixation Procedures," Am. Rev. Respiratory Disease 96:745-750 (October)1967.

The Parlett (PGD) test and a CF procedure were evaluated for the serologic diagnosis of active tuberculosis. Tests were made on 633 patients at admission and during hospitalization at the Missouri State Tuberculosis Sanitorium. Results with the PGD test showed poor correlation in two separate laboratories. The PGD test was positive in 50 per cent and the CF test in 59 per cent of culturally positive patients. Fifteen per cent and 26 per cent of the clinically and laboratory tuberculosis negative patients were positive with the PGD and CF tests respectively. The PGD test was positive with 33 per cent and the CF test with 38 per cent of the atypical mycobacteria infected patients. The PGD test was positive with 11-20 per cent of the patients having various other pulmonary diseases whereas the CF test was positive with 18-37 per cent. Generally the serologic test could not be relied upon to detect change or improvement of the tubercular disease in the patient under therapy.

Farrar, W. Edmund, M.D.; O'Dell, Noel M., B.S.; and Krause, Jane M., A.B., Emory University School of Medicine, Atlanta, Ga., "Use of Penicillinase Resistant Penicillins to Increase the Susceptibility of Gram-Negative Bacteria to Antibiotics," Annals of Internal Medicine 67:733-743(October)1967.

Many gram-negative bacteria elaborate beta-lactamases that inactivate penicillins and contribute to the antibiotic resistance of these organisms. Penicillinase-resistant penicillins, while ineffective as antibiotics against gram-negative bacteria, may act as penicillinase inhibitors and render these organisms more suspectible to penicillin G and related antibiotics. This phenomenon was studied in 100 strains of gram-negative bacteria highly resistant to penicillins or cephalosporins or both (31 *Klebsiella-Aerobacter,* 30 *Escherichia coli,* 31 *Pseudomonas,* and 8 *Proteus).* For each strain the minimal inhibitory concentration (MIC) for each of three *antibiotics* (penicillin G, ampicillin, and cephalothin) was determined. In addition, the MIC for each antibiotic was determined in the presence of 250 μg/ml of a penicillinase *inhibitor* (methicillin, oxacillin, or nafcillin). A significant positive interaction between antibiotic and inhibitor was observed with 86 per cent of the strains. With strains of the *Klebsiella-Aerobacter* group and of *E. coli* evidence was obtained that the effects observed were synergistic, whereas with strains of Pseudomonas the effects of the combinations were only additive. Penicillinase inhibition may represent a valuable approach to the treatment of infections caused by antibiotic-resistant gram-negative bacteria, especially those involving the urinary tract.

Dull, H. Bruce, M.D., National Communicable Disease Center, Atlanta, Ga., "Symposium on Immunization: Influenza Vaccine," Arch. Environ. Health 15:491-494(October)1967.

The utilization of influenza vaccine is greatly dependent on the cyclical characteristics of epidemic influenza and on the variability of the prevalent virus strains. Therefore, surveillance of the disease and of the influenza viruses becomes an integral part of recommendations for use of the available products.

Behal, Francis J., and Folds, James D., Medical College of Georgia School of Graduate Studies, Augusta, Ga., "Arylamidase of Neisseria catarrhalis," Archives of Biochemistry and Biophysics 121:364-371(August)1967.

The distribution of arylamidase activity among some common bacteria was studied. The activity predominated in Gram-negative organisms, and of these *Neisseria catarrhalis* was the richest source. Arylamidase from this organism was purified 548 fold by means of salt fractionation and column chromatography. The pH optimum was 7.3; no divalent or other metal ion requirement could be demonstrated. Heavy metal ions and p-chloromercuribenzoic acid were strongly inhibitory. Amino acid-β-naphthylamines were the only substrates hydrolyzed; of these the alanine derivative was hydrolyzed most rapidly. The leucine and methionine derivatives were also hydrolyzed at a significant rate. Puromycin was a competitive inhibitor of amino acid-β-naphthylamine hydrolysis. This bacterial arylamidase had neither γ-glutamyl transpeptidase nor leucine aminopeptidase activity.

Treadwell, Perry E., Ph.D., and Santos-Buch, Charles A., M.D., Emory University School of Medicine, Atlanta, Ga., "Disruption of Kupffer Cells During Systemic Anaphylaxis in the Mouse," Am. J. Pathology 51: 483-504(October)1967.

Evidence of rapid phagocytosis of soluble antigen-antibody complexes by Kupffer cells was observed within 2 min. following an intravenous injection in mice susceptible to the induction of anaphylaxis. When formation of phagosomes was observed within 5 min. following injection, vacuolation, budding and breaks in the limiting membranes of cytoplasmic dense bodies (lysosomes) occurred. Kupffer cells swelled, and 10 and 20 min. after injection, specific and characteristic breaks in the cytoplasmic membrane, nuclear envelope, and endoplasmic reticulum occurred. At these times, cytoplasmic dense bodies probably containing ferritin anti-ferritin complexes showed spillage of their contents into the cytoplasm. By 20 min. the contents of Kupffer cells often spilled into the lumens of hepatic sinusoids. Sequestration of erythrocytes and leukocytes within the liver sinusoids was then evident. Some of the sinusoids were denuded of lining Kupffer cells; others showed evidence of regeneration of the lining Kupffer cells. No alterations were observed in sequestered granulocytes and lymphocytes, or in the underlying hepatocytes.

Within 5 min. following an intravenous injection of soluble antigen-antibody complexes in these mice, diminution in levels of activity of heat- and formaldehyde-stable acid *p*-nitrophenylphosphatase in liver lysosome fractions was paralleled by an increase in levels of activity of this enzyme in the plasma. These same Ag-Ab complexes did not release this enzyme from fractionated liver lysomes in vitro, in the presence or absence of either mouse or guinea pig complement.

Pellets of lysosomal fractions prepared from homogenates of livers of mice injected with ferritin 10 min. before evisceration showed that membrane-bound dense bodies containing ferritin particles were the sites of heat- and formaldehyde-stable acid *p*-nitrophenylphosphatase. Lysosomal fractions from homogenates of livers of mice injected with solubilized Ag-Ab complexes 10 min. before evisceration showed evidence of morphologic changes comparable to those observed in vivo.

Freckleton, F. Robert, M.D., National Communicable Disease Center, Atlanta, Ga., "Symposium on Immunization: Federal Government Programs in Immunization," Arch. Environ. Health 15:512-514(October)1967.

The Federal Vaccination Assistance Act of 1962, administered by the National Communicable Disease Center, has provided grant funds to state and local health departments to strengthen immunization programs against diphtheria, pertussis, tetanus, poliomyelitis, and measles.

National surveys show significant improvement in the immunization status of the population during the last five years but further and continuing efforts are needed.

Identifying inadequately immunized pockets of susceptibles in a community is important, as is improved surveillance of diseases for which good immunizing agents are available, so that appropriate remedial measures can be undertaken.

Emphasis is placed on immunizing preschool children and on developing systems such as follow-up of birth certificates to assure immunization of virtually all infants. Many areas also are improving immunization programs for school children; some are active in adult immunization, especially with tetanus and smallpox.

Educational and promotional activities and community-based initiative are stressed. The most successful programs occur where the health department and medical society have worked together in planning promotional activities and the optimal utilization of their community's private and public resources.

Graham, Charles E., Ph.D., Emory University, Atlanta, Ga., "Mechanism of Induced Epidermization in the Mouse Uterine Cervix," Am. J. Obstetrics and Gynecology 99:470-478 (October 15)1967.

Various mechanisms have been proposed to account for the origin of new stratified squamous epithelium in the uterine cervix during intense estrogenic stimulation. In order to investigate this problem, pellets of diethylstilbestrol or estradiol benzoate were implanted subcutaneously into one month old animals. Two weeks to four months later, the animals were killed, serial sections of the cervices were prepared, and the distribution of the stratified epithelium was assessed, in some cases by means of an accurate mapping technique. After the shorter period of treatment, there was no gross increase in the amount of stratified epithelium in the cervix, although the appearance of a small number of isolated nodules of stratified epithelium indicated that a small amount of metaplasia was taking place. It was concluded from the absence of isolated nodules of stratified epithelium and other evidence of metaplasia in animals treated for four months, that the considerable amount of new stratified epithelium in the uterus of these animals must have arisen by proliferation and upgrowth of pre-existing cervical stratified epithelium.

Sulzer, Alexander J., Ph.D., and Hall, Elmer C., Ph.D., National Communicable Disease Center, Atlanta, Ga., "Indirect Fluorescent Antibody Tests for Parasitic Diseases IV. Statistical Study of Variation in the Indirect Fluorescent Antibody (IFA) Test for Toxoplasmosis," Am. J. Epidemiology 86:401-407(September)1967.

Essential to the use of any serologic test for diagnosis is a thorough knowledge of variability in the routine performance of the test. In this study, which was designed to evaluate the reproducibility of the IFA test for toxoplasmosis, six "blind" replicate titers were obtained on each of 50 sera by testing duplicates of each serum on different days. Previously determined MBD titers for these sera ranged from negative to 1:1024 in four-fold dilutions.

Based on an analysis of the variation in replicate determinations on the same day and on different days, confidence limits are given for the detection of "real" differences in titers. This information is particularly useful in instances where serologic diagnosis is based on changes in antibody titer, for example, in acute and convalescent sera.

IFA and MBD titers were quite similar, indicating the equivalence of the two tests in determining titer level. In addition, the IFA test is highly reproducible and quite stable over long periods of time.

Dull, H. Bruce, M.D., National Communicable Disease Center, Atlanta, Ga., "Symposium on Immunization: Public Health Service Advisory Committee on Immunization Practices," Arch. Environ. Health 15:531-536 (October)1967.

The Public Health Service Advisory Committee on Immunization Practices was appointed in the spring of 1964 to advise the Surgeon General on the most effective application of specific immunizing agents for communicable disease control in public health practice. Specific recommendations for immunization depend largely on a synthesis of immunological and epidemiological data and definition of the specific audience for which recommendations are formulated.

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HIGHLIGHTS OF THE ACTIONS OF THE MAG EXECUTIVE COMMITTEE AND COUNCIL MEETINGS, DECEMBER 9-10, 1967

This summary is being published so that the MAG membership may be advised in brief of the actions of the Association's Council and Executive Committee. It covers only major actions and is not intended as a detailed report. Full minutes of these meetings are available upon any member's request to the MAG Headquarters Office.

New MAG Executive Secretary, Mr. Edwin F. Smith, and the new AMA Field Service Representative, Mr. Gerald W. Blanchard, were introduced to the members of Council. It was reported that Mr. Smith will actually assume his duties at MAG on January 1, 1968.

MAG Contract With Military Medicare is to be renewed per unofficial notification from the CHAMPUS office in Denver. Dr. Haverty reported that he had been advised by OCHAMPUS that a contract for MAG signature would be forthcoming. He also advised that a supplemental agreement with this agency will result in maximum allowance increases in psychotherapy, anesthesia, O & O and certain procedures in urology, gynecology and obstetrics.

Board of Health Report was given by Board members Albert Tuck, D.D.S., and W. A. Dickson, M.D., on the current status of the mental health program and on legislation to be proposed at the '68 Legislature by the Health Department. Concurrent with these reports the Council adopted a statement to be referred to the Board of Health which requests that Title 19 be implemented to permit direct billing of patients and which recognizes the concept of usual, customary and reasonable fees for professional services.

Medicare and Title 19 Amendments were reported on by Dr. Walker and it was noted that H.R. 12080 as considered by the Conference Committee contained most of the provisions felt to be of the greatest concern to the AMA. Under State legislation the question of whether or not blood for transfusion constituted a "sale" or a medical service was discussed and the matter referred to the Legislative Committee with instructions to study and introduce corrective legislation if feasible. Also referred to the Legislative Committee for study was the matter of osteopathic practice, and possible repeal of citizenship requirements for medical licensure in Georgia.

Third Party Payments to Physicians in Teaching Institutions was reported on by Dr. Haverty. Dr. Dowda advised the Council that AMA House of Delegates in Houston had recommended a 12 point set of Guidelines for Hospital Programs that included among other things the point that "a hospital or medical school may not participate in the fees collected for medical services." The full 12 point set of guidelines was then endorsed and accepted as MAG policy.

Special Finance and Headquarters Expansion Committees reports were given in which the following recommendations were made and received for information: (1) No increase in membership dues until actual operating cost exceeds annual income, or until programs are developed that necessitate a dues raise; (2) No expansion of building for the purpose of attracting rental income. These committees will file annual reports to the 1968 MAG House of Delegates.

1968 CALENDAR OF MEETINGS

State

January 25-26—Perinatal Problems, Continuing Education Course, Medical College of Georgia, Augusta, Ga.

February 22-23—Internal Medicine: Recent Advances in Therapy, Continuing Education Course, Medical College of Georgia, Augusta, Ga.

February 23-24—American College of Physicians, Alabama Regional, Point Clear, Ala.

March 4-7—New Orleans Graduate Medical Assembly, New Orleans, La.

March 12-13—Basic Electrocardiography for the Practitioner, Continuing Education Course, Medical College of Georgia, Augusta, Ga.

March 19-20—Recent Developments and Clinical Applications in Obstetrics and Gynecology, Continuing Education Course, Medical College of Georgia, Augusta, Ga.

April 14-17—Atlanta Graduate Medical Assembly, Marriott Motor Hotel, Atlanta, Ga.

May 5-7, 1968—114th Annual Session of the Medical Association of Georgia, Town House, Augusta.

Regional

March 7-9—Southern Society of Anesthesiologists, Sheraton-Dallas Hotel, Dallas, Tex.

March 25-28—Southeastern Surgical Congress, Sheraton-Park Hotel, Washington, D.C.

National

January 11-13—First International Conference on Prematurity sponsored by AMA Department of Health Care Services, Pier 66, Lago Mar, Marina Motor Inn, Ft. Lauderdale, Fla.

January 14-18—Society for Cryo-Ophthalmology, Second Annual Meeting, Miami Beach, Fla.

January 15-19—Neurology and the Internist, American College of Physicians Postgraduate Course, University of Miami School of Medicine, The Eden Roc Hotel, Miami Beach, Fla.

January 17-18—American Rheumatism Association (Interim Meeting), Sheraton-Belvedere Hotel, Baltimore, Md.

January 18-20—National Conference on the Community and Emergency Medical Services, San Francisco Hilton Hotel, San Francisco, Calif.

January 19-20—American Society for Surgery of the Hand, Palmer House, Chicago, Ill.

January 20-25—American Academy of Orthopaedic Surgeons, Palmer House, Chicago, Ill.

January 29-31—Society of Thoracic Surgeons, Roosevelt Hotel, New Orleans, La.

February 2-3—American College of Psychiatrists, Fontainebleau Hotel, New Orleans, La.

February 3-7—American Academy of Allergy—Statler Hilton, Boston, Mass.

February 6-10—American College of Radiology, Drake Hotel, Chicago, Ill.

February 7-9—American Academy of Occupational Medicine, Marriott Twin Bridges Motel, Washington, D.C.

February 11-12—Congress on Medical Education, Palmer House, Chicago, Ill.

February 19-21—American College of Surgeons, Sectional Meeting, Statler Hilton, Dallas, Tex.

February 28-March 3—American College of Cardiology, San Francisco Hilton Hotel, San Francisco.

March 1-3—American Association of Pathologists and Bacteriologists, The Drake Hotel, Chicago, Ill.

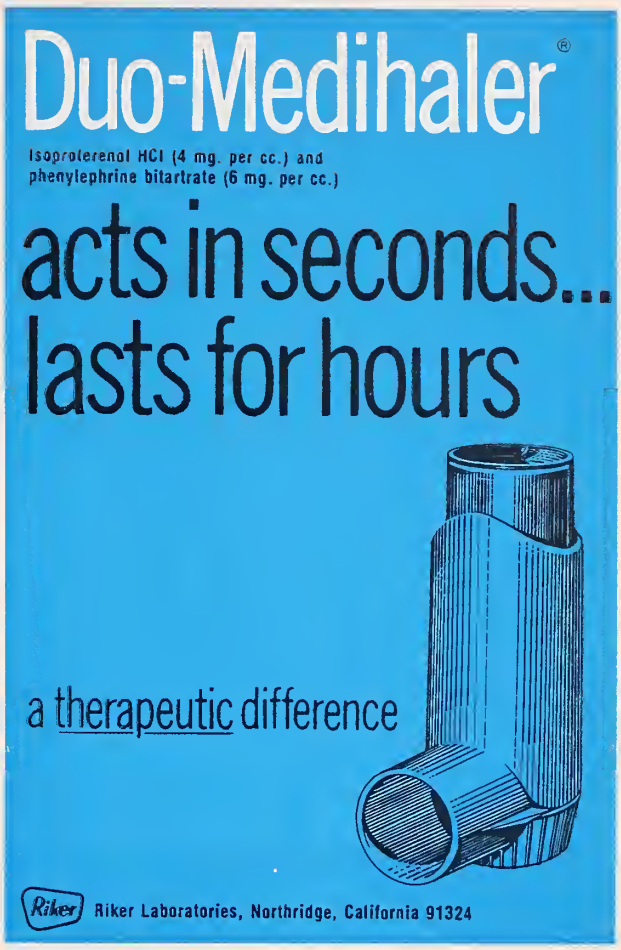
March 3-7—International Academy of Pathology, Drake Hotel, Chicago, Ill.

March 9-10—American Psychiatric Association Colloquium on Postgraduate Teaching of Psychiatry, Roosevelt Hotel, New Orleans, La.

March 11-13—American College of Surgeons (Sectional Meeting for Doctors and Nurses), Williamsburg Inn, Williamsburg, Va.

March 15-16—AMA Council on Mental Health Conference of State Mental Health Representatives, Drake Hotel, Chicago, Ill.

March 15-20—International Congress of Lymphology, Fontainebleau Hotel, Miami Beach, Fla.



March 16—Advances in Gynecological Endocrinology, Vanderbilt University, Nashville, Tenn.

March 18-20—American Academy of Pediatrics, Regency-Hyatt House, Atlanta, Ga.

March 22-23—National Congress on the Socio-Economics of Health Care, Palmer House, Chicago, Ill.

March 24-30—American Society of Clinical Pathologists (Interim), Roosevelt Hotel, New Orleans, La.

March 30-April 3—American Society of Abdominal Surgeons, Sherman House, Chicago, Ill.

April 4-6—National Conference on Health Education of the Public, Pick Congress Hotel, Chicago, Ill.

April 5-6—Committee on Disaster Medical Care Regional Conference on Disaster Medical Care, Statler Hilton Inn, Durham, N.C.

April 7-11—American Radium Society, Fontainebleau Hotel, Miami Beach, Fla.

April 9-12—American Association of Anatomists, Jung Hotel, New Orleans, La.

April 10-12—Plastic Surgery Research Council, University of North Carolina, Chapel Hill, N.C.

April 16-17—American Association of Planned Parenthood Physicians, Gunter Hotel, San Antonio, Tex.

April 21-22—American Broncho-Esophagological Association, Hollywood Beach Hotel, Hollywood Beach, Fla.

April 21-26—American Laryngological, Rhinological and Otological Society, Hollywood Beach Hotel, Hollywood Beach, Fla.

April 22-25—American Orthopaedic Association, Boca Raton Club, Boca Raton, Fla.

April 25—American Society for Head and Neck Surgery, Hollywood Beach Hotel, Hollywood, Fla.

April 25-26—American Geriatrics Society, Roosevelt Hotel, New Orleans, La.

April 27-May 1—American Academy of Facial Plastic and Reconstructive Surgery, Diplomat Hotel, Hollywood Beach, Fla.

April 28-May 1—American Association of Plastic Surgeons, Shamrock-Hilton Hotel, Houston, Tex.

June 16-20—American Medical Association Annual Meeting, San Francisco, Calif.

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THE MONTH IN WASHINGTON

Washington, D.C.—The National Advisory Commission on Health Manpower reported that the nation's health care system must be improved to assure that quality health care is available to all Americans at a reasonable cost.

The 15-member Commission, in its report to President Johnson, urged a substantial expansion in the capacity of existing medical schools and continued development of new schools. At the same time, the advisory group said that "although the need for more physicians is urgent, the costs and dangers of a crash effort to increase production appear to outweigh the benefits."

Manpower Not Enough

The Commission members agreed that tackling the problem of manpower, alone, would not cure present ills.

". . . If additional personnel are employed in the present manner and within the present patterns and systems of care, they will not avert, or even perhaps alleviate, the crisis," the Commission said.

"Unless we improve the system through which health care is provided, care will continue to become less satisfactory, even though there are massive increases in costs and in numbers of health personnel."

The Commission recommendations were accompanied by an assertion that government alone is not big enough to solve the problems of health care for the American people.

The American Medical Association's House of Delegates at its recent meeting in Houston, Tex., approved a report of the Board of Trustees on the Commission's report. The Board stated:

"The 'Report of the National Advisory Commission on Health Manpower' reflects much of the serious attention given to the evolving needs of health care long recognized, studied and implemented by the American Medical Association and other professional groups in the health fields.

"The House of Delegates and the Board of Trustees of the AMA have not had time to study the Report carefully. . . . However, it appears to recognize the needs arising from the rapid growth of the public's desire for health care. This attitude is the result of increasing awareness of the great advances in medical science and techniques, and of the prolongation of life for millions into middle and advanced ages. . . .

"The Report will receive the intensive study of the various expert groups within AMA and reports on their recommendations will be issued as soon as they can be developed properly. There appear to be some areas in which modifications will be necessary to assure attaining the objectives sought for advancement of health care for all citizens."

Proposals

The Commission's proposals included:

Federal funds in support of capital or operating costs of education should be provided to a medical school in such a way that they create economic incentives for the school to expand enrollment while improving its quality.

The federal government should make available to any medical student loans to cover the full costs of tuition and living expenses during formal professional education. The student should be able to choose between re-

paying the loan from earnings over a period of years or giving two years of his time to approved national service apart from Selective Service obligations.

The federal government should give high priority to the support under university direction of experimental programs which train and utilize new categories of health professionals.

At a minimum, foreign-trained physicians who will have responsibility for patient care should pass tests equivalent to those for graduates of U.S. medical schools.

The Selective Service Act should be amended to provide for the automatic transfer of the records of every draft-eligible health professional, upon his graduation from professional school, from the local board of his original registration to the local board in whose jurisdiction he works and for subsequent transfer with each change in the location of his work.

The Selective Service Act should be amended to provide equal draft-liability for U.S. and foreign medical graduates.

Service with the U.S. Public Health Service should be phased out as a substitute for the military obligation of health professionals.

The Department of Defense should be instructed to encourage the greater use of the Military Medicare Amendments of 1965 and should study the feasibility of utilizing voluntarily obtained health professionals in military facilities located in the United States.

Nursing should be made a more attractive profession by such measures as appropriate utilization of nursing skills, increased levels of professional responsibilities, improved salaries, more flexible hours for married women, and better retirement provisions.

Programs for health care of the disadvantaged should be given highest priority and made available wherever needed.

Professional societies, universities, and state governments should undertake, with federal support, studies on the development of guidelines for state licensure codes for health personnel.

Professional societies and state governments should explore the possibility of periodic relicensing of physicians and other health professionals.

Professional societies, health insurance organizations, and government should extend the development and effective use of a variety of peer review procedures in maintaining high quality health and medical care.

Mental Retardation Bill

President Johnson signed a $281 million mental retardation bill with a statement that the nation still is not doing enough to solve the problem.

The bill strengthens federal aid for the construction of new facilities for the mentally retarded.

He also signed a three-year, $589 million extension of federal aid for state public health programs.

It provides for federal licensing of clinical laboratories operating in interstate commerce unless they are run by pathologists, in which case the facilities would have to meet standards set by the American College of Pathologists or the American Hospital Association. Individual physicians operating labs for their own patients would not be affected by the new law.

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December 6, 1967

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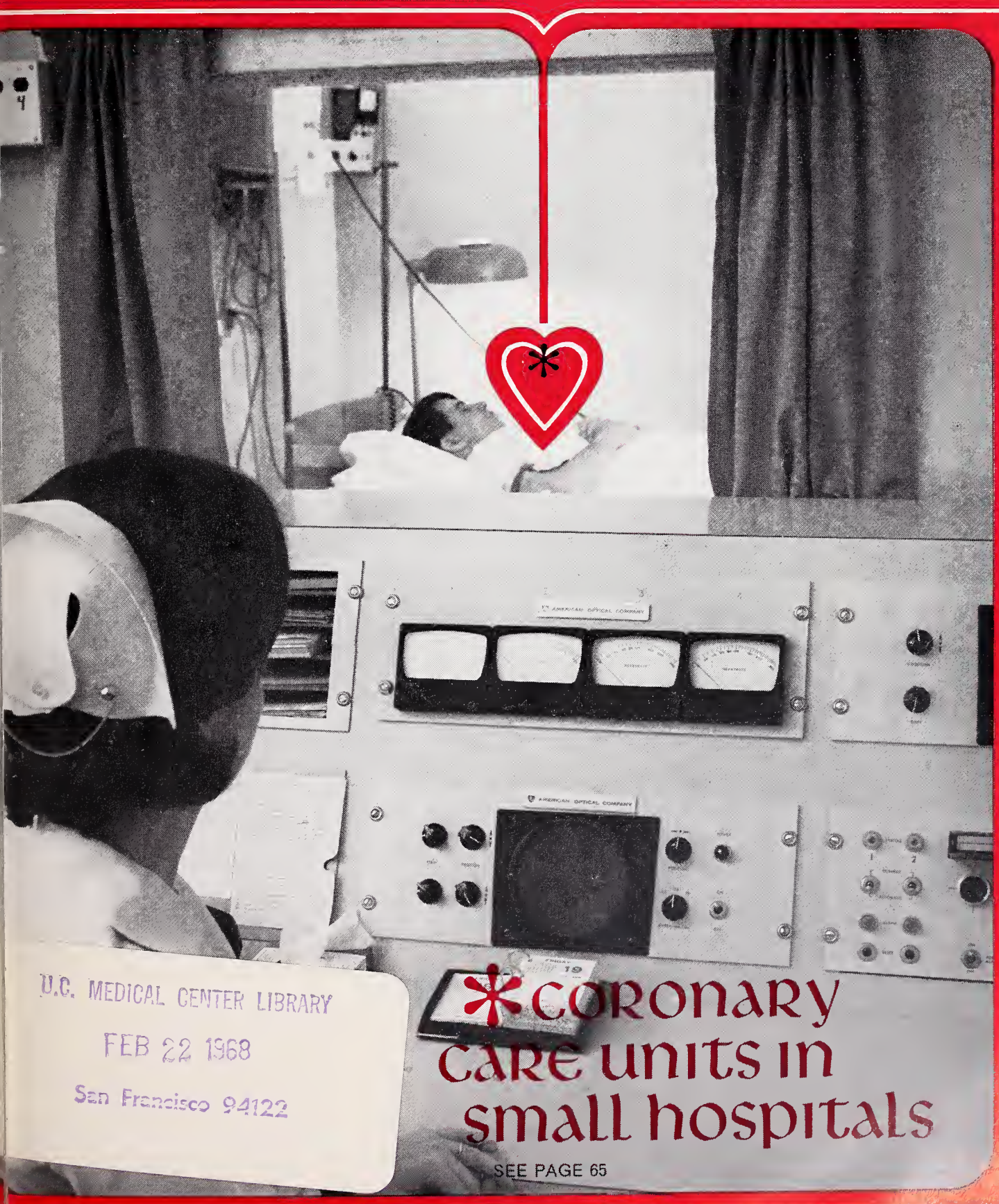

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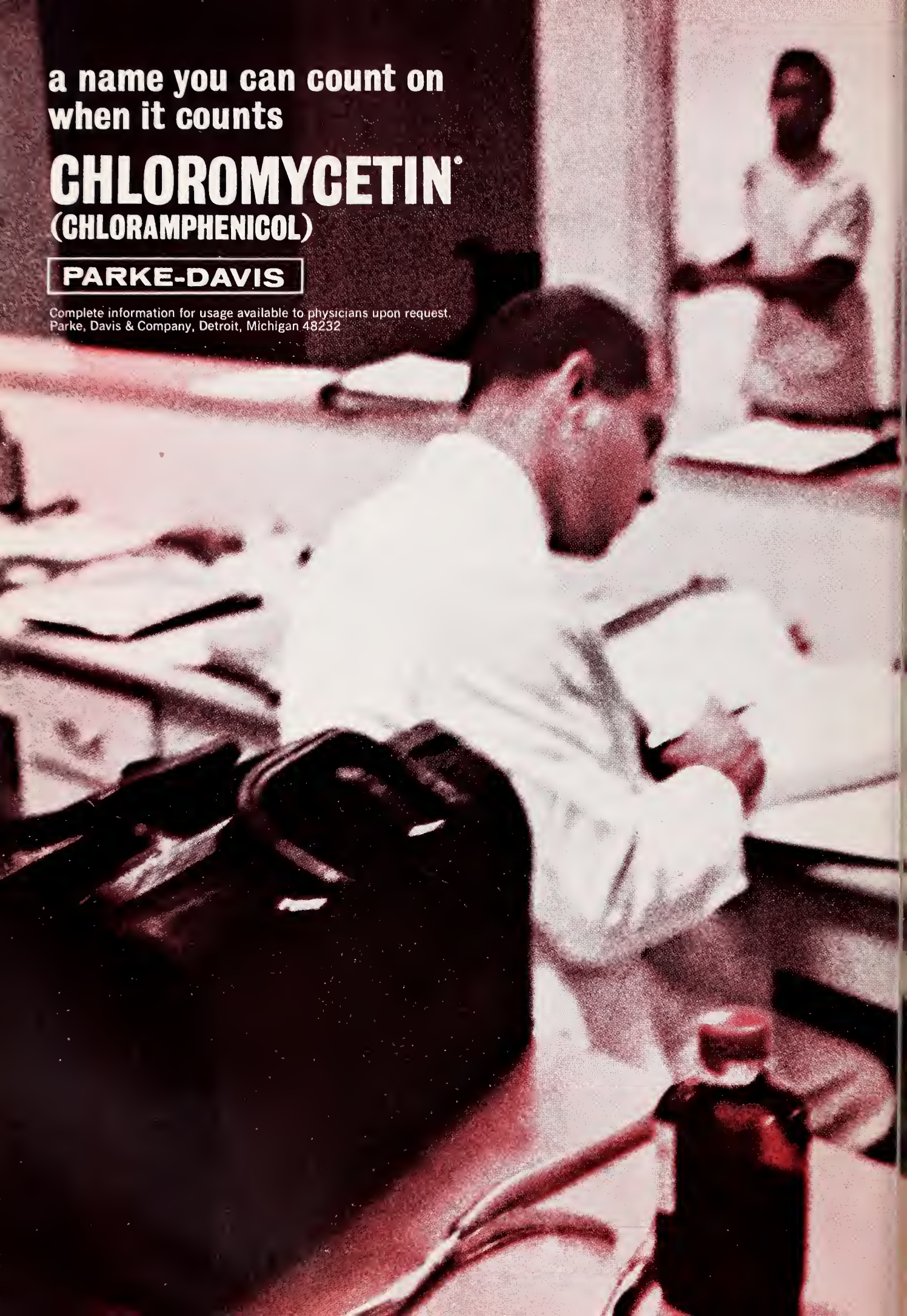

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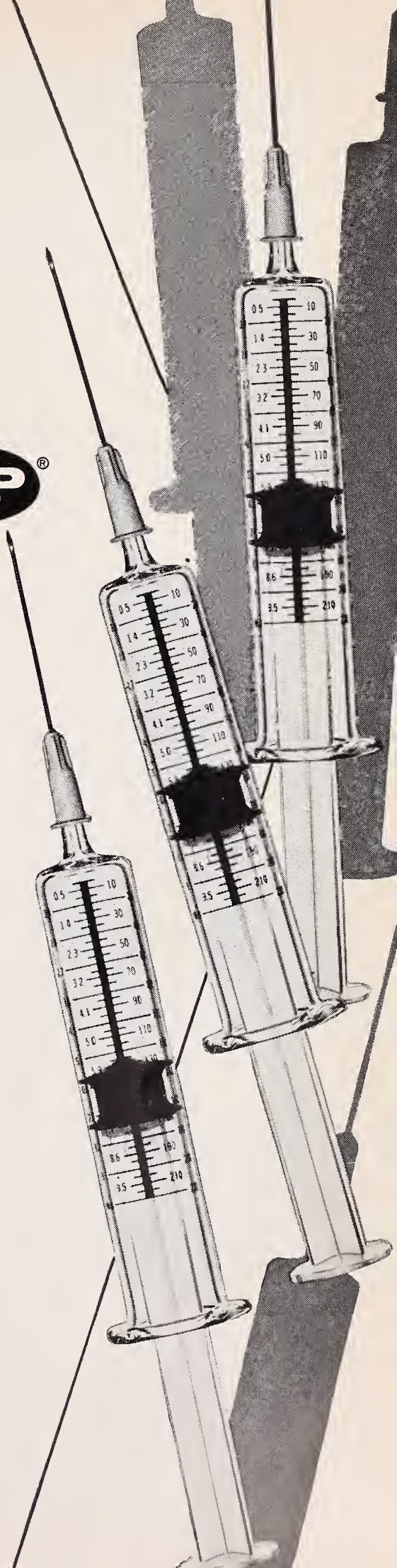

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JOURNAL OF THE MEDICAL ASSOCIATION Georgia

The disease includes a spectrum of physiologic abnormalities characterized by an otherwise unexplained defect in glucose tolerance and beta cell decompensation.

Diabetes Mellitus: What Is It?

JOHN K. DAVIDSON, M.D., ***Toronto, Ontario, Canada***

For some years, medicine has been flushed with the enthusiasm generated by progress in biochemistry, electron microscopy, and other areas of biological investigation. In such an atmosphere, it is easy for us to lose sight of how much we do not know. During the last seven years, most of my time has been spent pondering various approaches to the question: "What is diabetes mellitus?" The vexing problems inherent in detecting and treating individuals who make up the diabetic population alert us to the fact that, at best, the question can be answered only in part. A general survey of knowledge of, unproved theories relating to, and ignorance concerning diabetes mellitus can provide the perspective necessary to identify useful targets for further investigation. As such targets are identified and successfully assaulted, our knowledge and ability to cope with now perplexing clinical problems can also grow. The objective of this presentation is three-fold: (1) to indicate the spectrum of physiologic abnormalities characterized by a loss of glucose tolerance that are classified clinically as diabetes mellitus; (2) to point out some targets that seem worthy of further investigation; and (3) to comment briefly on the recent assault on one target that has yielded clinically useful information.

During this discussion, there is not sufficient time to discuss the hereditary aspects of the disease or the inadequacies of current methods of establishing the diagnosis. Though the familial incidence of the disease is well-documented, it is reasonably clear that it can no longer be regarded as simply Mendelian recessive in character.[1] It is also clear that environmental factors play a more important role in initiating the disorder than was formerly thought to be the case. Though there is no satisfactory alternative to the glucose tolerance test in establishing the diagnosis, we are more aware than ever before of the difficulty in interpreting a borderline test.[2] We are also aware that a normal test provides no guarantee that the disorder will not subsequently develop, and that a clearly abnormal test may revert to normal either spontaneously or when abnormal substrate or hormone loads are removed from the affected individual.

Physiologic Abnormalities

A comprehensive view of diabetes mellitus makes it necessary to identify the underlying physiologic abnormalities[3] that are responsible for the otherwise unexplained defect in glucose tolerance which is accepted as the *sine qua non* of the disease. This in turn requires some understanding of metabolic homeostasis, and the manner in which various substrates and hormones interact in the normal animal to maintain the delicate balance between anabolism and catabolism, and what happens in the diabetic animal whose insulin production is inadequate to sustain optimal anabolic activity. Figure 1 illustrates the relationship between the metabolic need for insulin and insulin production. In the normal animal, insulin is synthesized and secreted according to

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From the Department of Physiology and the Department of Medicine, Faculty of Medicine, University of Toronto.
Presented at the 113th Annual Session of the Medical Association of Georgia, May 1, 1967, Atlanta, Georgia.

metabolic need, the blood glucose is regulated within a narrow range, and normal carbohydrate tolerance is maintained. If the beta cell mass is removed, seriously damaged, or reduced below a critical level for any reason, insulin production is insufficient to maintain normal anabolic activity. In these circumstances, diabetes mellitus is said to be present. In other parts of the spectrum of physiologic abnormalities classified as diabetes mellitus, the influence of factors outside the beta cell mass may be of great importance, though here too anabolic activity remains normal as long as the beta cell mass can adapt to the increased metabolic need for insulin. There is an increased need for the anabolic hormonal effects of insulin in animals subjected to increased food intake during growth (growth spurt, pregnancy), or to chronic substrate overload (obesity), or to abnormal levels of hormones that elevate the level of blood glucose by their predominantly catabolic influence on carbohydrate (thyroid hormone, glucagon, adrenaline), protein (ACTH, 11-oxysteroids, glucagon, thyroid hormone), or fat (growth hormone) metabolism. To supply the anabolic need for insulin in the presence of obesity, excessive substrate intake, or pregnancy, or in the presence of excessive amounts of growth hormone, ACTH, 11-oxysteroids, thyroid hormone, glucagon, or adrenaline, insulin production may increase and the beta cell mass may grow within limits. Since this adaptive ability of the beta cells is not without limit, however, carbohydrate intolerance eventually develops in many such individuals even though they may be producing more insulin than normal individuals who retain normal carbohydrate tolerance. Thus carbohydrate intolerance may develop at very low, normal, or fairly high levels of insulin production when the reference level is that of the normal non-diabetic population. It does not occur in a given individual until his metabolic need for insulin exceeds the ability of his beta cell mass to meet that need.

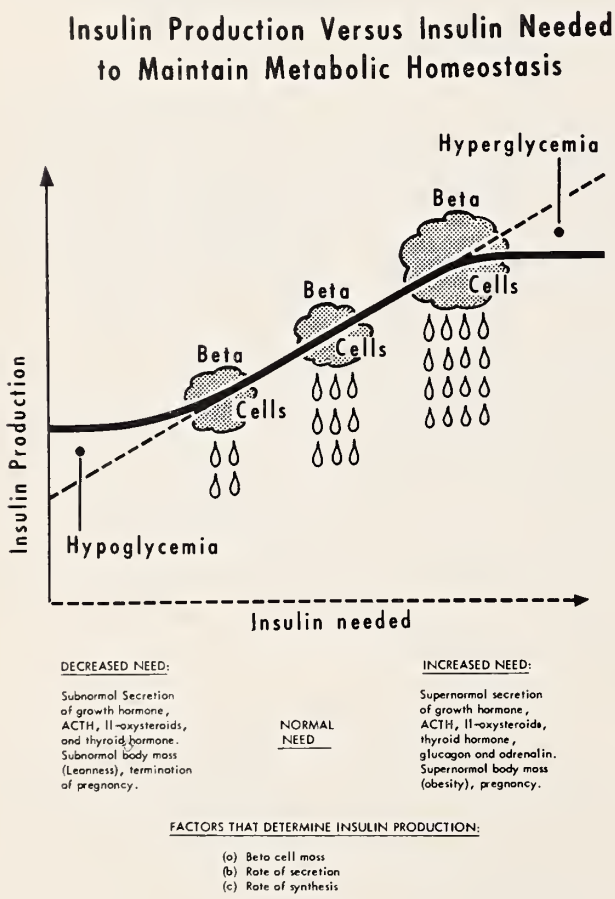

FIGURE 1

Insulin production (ordinate and solid black line) matches insulin need (abscissa and broken line) and a precise balance between anabolism and catabolism is maintained in the normal animal. Beta cell adaptability is limited and insulin secretion may be excessive in the absence of contra-insulin hormones so that fasting hypoglycemia develops or it may be insufficient so that hyperglycemia develops (1) when the beta cell mass and insulin secretion are insufficient to supply the need of the metabolically unstressed organism, or (2) when the beta cell mass and insulin secretion become insufficient (beta cell decompensation) to supply the need of organisms at various levels of metabolic stress. See text for discussion.

In planning therapy for each individual with diabetes mellitus, factors that subject the beta cells to abnormal stress should be removed. Reduction of the substrate load and body weight to normal can accomplish this in many individuals, and removal of sources of abnormal hormone production can do so in others. Beta cell compensation may be restored in some individuals by changing the pattern of insulin secretion by administration of a sulfonylurea compound.[4] In animals, such therapy may cause beta cell growth.[5] When these measures fail to restore beta cell compensation because the beta cell mass is insufficient to supply the amount of insulin needed to re-establish metabolic homeostasis, it is necessary to supplement the supply of endogenous insulin by injection of exogenous insulin.

Experimental Diabetes

Much of our understanding of the nature of diabetes mellitus originated in studies of the experimentally induced disease in animals or in abnormal metabolic patterns in isolated tissues obtained from such animals. Table 1 indicates that all forms of experimentally induced diabetes are associated with a relative deficiency of insulin, and that in each type of experimental diabetes, injection of a sufficient amount of exogenous insulin will correct the abnormal metabolic pattern. Following surgical pancreatectomy, the dog usually dies in diabetic coma within one week. When the beta cell mass is sufficiently reduced by partial pancreatectomy, chemical injury by alloxan or other betacytotoxic materials, or by growth hormone administration to mature sen-

sitive dogs, chronic hyperglycemia results. The animal may remain alive for several months or longer, indicating that some beta cells remain. If the animal is able to regenerate enough beta cells in response to the metabolic need, glucose tolerance may become less abnormal or may return to normal. Growth hormone administration does not induce diabetes in puppies or rats because beta cell hyperplasia provides the additional insulin needed to meet the metabolic demand. Administration of ACTH, glucocorticoids, thyroid hormone, or large amounts of glucagon may produce a transiently abnormal glucose tolerance test in normal animals, and the same materials may produce permanent diabetes in partially pancreatectomized animals. When insulin is administered along with growth hormone, ACTH, glucocorticoids, or thyroid hormone, the beta cells are usually protected and diabetes does not result. Infusion of serum obtained from guinea pigs that are immune to cattle insulin induces an acute insulin deficiency in normal animals. If small amounts are given, the animal recovers quickly. If large amounts are given, the animal may die in diabetic coma. Injection of exogenous cattle insulin into rabbits may induce insulin immunity, beta cell destruction, and permanent diabetes.

Human Beta Cells

Spontaneous diabetes in humans and animals is associated with a relative deficiency of insulin production (Table II). In contrast to the earlier findings of MacLean and Ogilvie,[6] it has been recently shown by Gepts[7] that the beta cell mass is always significantly reduced in both juvenile onset and maturity onset diabetes. Beta cells are rarely seen in the pancreas of juvenile diabetics autopsied shortly after the onset of the disease. Beta cells that remain tend to be degranulated and infiltrated with glycogen, suggesting that the remaining beta cells are secreting insulin at peak capacity. In some juvenile diabetics, the islets are infiltrated with lymphocytes, and beta cells are necrotic and contain pyknotic nuclei. This suggests that an infection or some other destructive process may be taking place in the islets. Rare islets may be hyperplastic, but the total islet mass is always significantly reduced. In older diabetics, the islets are frequently fibrotic or hyalinized.

ALL FORMS OF EXPERIMENTALLY INDUCED DIABETES MELLITUS ARE ASSOCIATED WITH A RELATIVE DEFICIENCY OF INSULIN

1. **Pancreatectomy, total or partial.**
2. **Chemical injury to islets, i.e. alloxan.**
3. **Injection of growth hormone, ACTH, 11 oxysteroids, thyroid hormone, glucagon.**
4. **Infusion of guinea pig serum containing insulin neutralizing antibodies.**
5. **Immunity induced by injection of exogenous insulin.**

In each case, injection of sufficient amounts of exogenous insulin will correct the abnormal metabolic pattern.

TABLE I

SPONTANEOUS DIABETES MELLITUS IN HUMANS AND ANIMALS IS ASSOCIATED WITH A RELATIVE DEFICIENCY OF INSULIN

1. **Reduced beta cell mass.**
2. **Beta cell degranulation.**
3. **Decreased extractable insulin of pancreas.**
4. **Decreased blood insulin. (In early diabetes, native serum insulin activity may be elevated, but treated serum insulin activity is not.)**
5. **Therapeutic response to injected insulin.**
6. **Therapeutic response to tolbutamide when sufficient beta cell mass remains.**

TABLE II

Extractable Insulin

The normal adult human pancreas contains about 16 mg or 400 units extractable insulin. About ten per cent of this insulin is secreted each day and is replaced by newly synthesized insulin. The insulin extractable from the pancreas of maturity onset diabetics is usually from 25 to 75 per cent of that extractable from the normal pancreas, while the insulin extractable from the pancreas of the juvenile onset diabetic is one to two per cent of normal.[8] We have used the mouse hemidiaphragm insulin assay to measure insulin activity levels in serum which has been treated with acid alcohol and dialyzed.[9, 10] Serum samples were collected after an overnight fast from 22 normal humans, 44 diabetics not on insulin therapy, and 38 diabetics on insulin therapy (24 hours after the last injection of insulin) and were assayed under code* (Figure 2). The mean level in normals was 3.48 milliunits insulin activity per ml serum (range 0.8-8.0 milliunits per ml). The mean level in the non-insulin treated diabetics was 1.67 milliunits per ml serum, less than half the mean level in the normals. None of the non-insulin treated diabetics had a level as high as the upper normal range. The non-insulin treated diabetics were subdivided into groups on the basis of body weight and whether or not they were on a sulfonylurea drug. The mean level in each subgroup was still distinctly subnormal, though the obese diabetics and those on sulfonylurea therapy tended to have slightly higher levels than did the lean diabetics on diet therapy alone. Twenty-four of the insulin treated diabetics had levels that fell within the normal range, while 14 (37 per cent) had levels that were above the normal range. Subsequent studies showed that those with elevated levels had

** I am indebted to Dr. Barbara Hazlett for collecting these samples.*

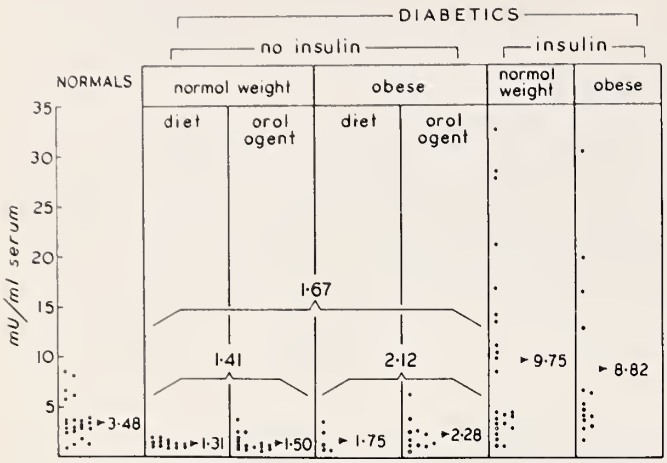

FIGURE 2

Comparison of insulin activity levels in acid alcoholic treated dialyzed serum obtained from overnight fasted normals, non-insulin treated diabetics, and insulin-treated diabetics and assayed under code by the mouse hemidiaphragm insulin assay.

significant titers of insulin neutralizing antibodies which were binding insulin that was released by treatment of the serum with acid alcohol. In another investigation, the mean level of insulin activity measured in serum obtained from a group of non-insulin treated diabetics during a glucose tolerance test was below the mean level measured in serum obtained from normal individuals during a glucose tolerance test.

Beta Cell Growth

We know very little about beta cell metabolism, renewal, and growth in the normal and diabetic populations. We do know that the beta cell mass seems to be particularly susceptible to damage by chemical agents such as alloxan, and we have reason to suspect that the cells may be damaged by infections and autoimmune processes. We know that hemachromatosis, chronic pancreatitis, and carcinoma of the pancreas can induce sufficient beta cell damage to produce diabetes. Gradual deterioration in the endocrine function of the beta cells in partially pancreatectomized dogs and in dogs in whom pancreatic autotransplantation[11] has been performed suggests that in these circumstances beta cell renewal may be severely restricted, and the beta cell mass may gradually grow smaller as aging cells disappear. The mitotic activity of beta cells in insulin antibody injected mice with sustained hyperglycemia has been studied recently by Logothetopoulos and Bell.[12] They found that beta cells always arose from preexisting beta cells, and found no evidence that beta cells arose from ductular epithelium. This indicates that there is no source of beta cell renewal apart from the already existing beta cell mass. They found that mitotic activity was maximal three days after onset of antibody injections. Mitotic activity then progressively declined despite continued hyperglycemia. It was no higher in most antibody injected mice than in control mice after fifteen days. It thus appears that beta cells that are maximally synthesizing secretory protein (insulin) may be biochemically handicapped for cell division. In adult human beta cells, mitoses are seldom observed.[13] The evidence tempts one to speculate that beta cell renewal and growth in at least some species of animals is strictly limited. We need to know a great deal more about genetic and environmental factors that promote or restrain beta cell renewal, and we need to know more about presently elusive factors that may cause selective beta cell destruction.

Other Theories of Etiology

The evidence that diabetes mellitus is always due to beta cell decompensation has been summarized. Table III lists some of the theories concerning the etiology of the disease that have received or are receiving prominent support. In order to place our knowledge of diabetes in proper perspective, we must consider the experimental studies underlying these theories and try to identify any targets worthy of further investigation. If experimental evidence indicates that a theory is barren of potentially productive ideas, it should be jettisoned so that concepts of etiology will be simplified and confusion minimized.

The concept of *insulin antagonism* has dominated a large segment of diabetes research for a number of years, and it still plays a prominent role in nearly

SOME THEORIES CONCERNING THE ETIOLOGY OF DIABETES MELLITUS

X	(1)	Growth hormone excess.
X	(2)	Plasma insulin inhibitor (synalbumin).
X	(3)	"Excessive" insulin secretion after a glucose load, thus tissues are "resistant" to insulin action.
X	(4)	Excessive free fatty acid release by adipose tissue prevents normal glucose utilization. Resultant hyperglycemia causes beta cell exhaustion.
X	(5)	Chemically defective, thus biologically inadequate insulin molecule.
X	(6)	Excess insulin destruction ("insulinase" or glutathione-insulin transhydrogenase).
X	(7)	Failure of "bound" insulin to break down to "free" insulin when blood glucose rises.
X	(8)	In vivo alloxan production.
?	(9)	Infection of islets.
?	(10)	Autoimmunity.

X = appears to be ruled out by currently available evidence.
? = needs further study.

TABLE III

all discussions concerning the etiology of the disease. Many of the theories go beyond the idea that various peripheral tissue and hormonal factors may increase the metabolic need for insulin to a point at which the beta cells are incapable of secreting enough insulin to meet the need. Some of them suggest that the primary defect is present in the tissues themselves and that for this reason the tissues are unresponsive to insulin. Others suggest that tissue responsiveness to insulin is subnormal because hormonal or plasma factors present at the tissue site interfere with insulin action. Others suggest that the insulin is prematurely destroyed or is chemically defective and thus biologically inadequate. Others suggest that endogenous or exogenous environmental factors may cause beta cell destruction, and they thus recognize the primary role of beta cell failure in the etiology of diabetes.

Hypophysectomy Diminishes Severity

Over thirty-five years ago, Houssay[14] demonstrated that the severity of diabetes in pancreatectomized animals was diminished by hypophysectomy, that hypophysectomized animals were exquisitely sensitive to insulin, and that injections of pituitary extracts could induce diabetes. Young[15] induced permanent diabetes in mature dogs by injecting anterior pituitary extracts, and this effect was subsequently shown to be due to growth hormone. It is not surprising that these experiments generated excitement and diverted attention from the beta cells as the primary site of pathology in diabetes mellitus. They also laid the groundwork for the subsequent evolution of various concepts of insulin antagonism. These concepts have been reinforced by demonstrated effects of hormones (adrenal glucocorticoids, ACTH, thyroid hormone, glucagon, and adrenaline), pregnancy, and obesity in blunting the hypoglycemic effect of a given amount of insulin.[3] That such metabolic states increase the need for insulin is unquestioned; the possibility that they induce diabetes in a significant number of humans with an adequately responsive beta cell mass appears remote.

Plasma growth hormone levels are normal in diabetics[16] and only 25 per cent of acromegalics who have sustained elevation of growth hormone levels become diabetic; thus it seems unlikely that elevated growth hormone levels are of etiologic significance in the vast majority of human diabetics.

The presence of the synalbumin insulin inhibitor described by Vallance-Owen[17] is said to depend on the presence of growth hormone and adrenal steroids in the donor animal. Plasma from diabetics not treated with insulin does not inhibit the effect of added insulin, and infusion of large amounts of the B chain of insulin which is thought to be an integral part of the inhibitor does not elevate the blood glucose. Studies of the influence of "inhibitory" albumin on glycogen synthesis by the mouse hemidiaphragm (rather than on glucose uptake by rat hemidiaphragm) indicated that the effect was not due to a specific inhibition of the hormonal activity of insulin, but was due to a noxious effect of the material on diaphragm metabolic activity.[18] Thus the possibility that the synalbumin plasma insulin inhibitor is of physiologic significance seems unlikely.

The report of MacLean and Ogilvie[6] that islets in some juvenile onset diabetics were hyperplastic directed attention to the possible primary significance of factors outside the beta cell mass in initiating the disease. Gepts[7] later contradicted these findings. The most recent studies which have directed attention away from the islets and towards peripheral factors are the findings that ILA and immunoreactive insulin levels[19, 20] may be elevated in early diabetes. These findings suggested that the tissues were "resistant" to insulin action. Subsequent reports by others[21] and those previously reported in this communication have not found elevated insulin activity levels in serum. It has also been shown that the tissues of diabetics and normals give equivalent metabolic responses to equal amounts of insulin both in vivo and in vitro. Therefore the idea that the tissues of the diabetic are resistant to the action of insulin appears to be ruled out. Randle[22] suggested that the initial defect in diabetes may be excessive free fatty acid release from adipose tissue and that this in turn prevents normal glucose utilization and leads to hyperglycemia, high levels of insulin secretion due to "insulin antagonism," and beta cell exhaustion. However, glucose levels in diabetes do not rise until insulin production is insufficient. If insulin production is already insufficient, it is redundant to suggest that antagonism to insulin action in peripheral tissues accounts for the beta cell deficit.

Insulin From Diabetics the Same

It has been suggested that insulin from diabetics is chemically defective and thus biologically inadequate. This possibility appears to be ruled out by the finding that the structure of insulin extracted from the pancreas of normal and diabetic individuals is the same and that insulin from the diabetic pancreas has the same activity on a weight basis as that from a normal pancreas.[23] It has also been suggested that insulin is destroyed more rapidly in diabetics than in normals, perhaps by "insulinase" or glutathione-insulin transhydrogenase.[24] This possibility appears to be ruled out by the normal disappearance time of injected unlabeled and I-131 labeled in-

sulin in early diabetes.[25] The suggestion of Antoniades[26] that biologically inactive "bound" insulin fails to break down to biologically active "free" insulin when the blood glucose rises has not been confirmed.

The suggestion that endogenous production of alloxan or some other metabolic product damages the beta cells has not been confirmed. The possibilities that the onset of diabetes, especially in juveniles, may be related to infection with destruction of the beta cells or to some autoimmune mechanism have been inadequately investigated and deserve further study.[27] Italian investigators have recently documented an epidemic of diabetes mellitus occurring in a herd of cattle two months after an epidemic of foot and mouth disease due to type C virus.[28] On autopsy, the islets were infiltrated with lymphocytes, the beta cells had largely disappeared, and those that remained had pyknotic nuclei and glycogen infiltration. Antibodies in the serum have not been demonstrated in diabetics prior to the onset of insulin therapy, but destructive islet lesions and diabetes have been induced in rabbits by the injection of cattle insulin.[29]

Sulfated Insulin

Immunological insulin resistance due to formation of insulin neutralizing antibodies has been a troublesome though rare complication of diabetes for which no completely satisfactory therapy has been available until recently. An example of what can be accomplished in the face of such a problem is illustrated by the development of sulfated insulin. Moloney, who first produced insulin antibodies in experimental animals, studied various chemically modified insulins for their biological activity and for their ability to combine with antibodies to unmodified beef insulin. He and his co-workers found that sulfated insulin reacted poorly with antibodies to beef insulin and was less antigenic than unaltered insulin but retained most of its biological activity.[30] Insulin resistant patients usually require only 10 to 20 per cent as much sulfated insulin as unmodified insulin for control. Up to the present time, approximately 50 insulin resistant patients in Canada have been successfully treated with sulfated insulin.

I am indebted to Dr. W. T. W. Clarke for permission to report the following patient, who demonstrates the typical response of an insulin resistant patient to therapy with sulfated insulin.

Case Report

Mrs. E.W., a 61-year-old woman, was found to have diabetes mellitus in the autumn of 1964. Initial therapy consisted of dietary restriction; later tolbutamide was added. Protamine zinc insulin therapy was started in early 1966 and for three months diabetic control on 25 units per day was satisfactory. Her insulin requirement gradually increased and by November 1966 was 100 units PZI per day. In December she was taking 145 units PZI and 15 units regular insulin per day. In January 1967 she was switched to regular insulin twice daily, and on February 16, 1967, she was taking 140 units regular insulin before breakfast and before supper (280 units daily). From July 1966 until admission to the Toronto General Hospital on February 16, 1967, she had persistent four-plus glucosuria, and she had lost 50 pounds despite a fairly high caloric intake. *Family history:* mother had diabetes mellitus. *Past history:* a subtotal thyroidectomy in 1944 and again in 1952 for hyperthyroidism due to hyperplastic adenomata. Rheumatic heart disease with mitral insufficiency and atrial fibrillation, with congestive failure two years prior to admission. Well compensated on hospital admission on 50 mg hydrodiuril and 0.25 mg digoxin per day; able to walk one block without dyspnea. On the day of hospital admission at 6 a.m. blood glucose was 405 mg per 100 ml and at 11 a.m. it was 519 mg per 100 ml. Urine contained 4+ glucose and a moderate amount of acetone. She had a significant titer of insulin neutralizing antibodies in her serum. Without further delay, she was started on sulfated insulin before breakfast and before supper. She was given a 1600 calorie diabetic diet. Initial daily dose of 40 units was gradually increased to 135 units per day. In one week the blood glucose was 133 mg per 100 ml at 4:30 p.m. She then started having hypoglycemic reactions before supper, and the dose of sulfated insulin was reduced to 60 units before breakfast and 35 units before supper. On this dose she remained aglucosuric and blood glucose levels were normal. Her weight increased from 137 to 145 pounds during her hospitalization. She was discharged on March 4, 1967, on 60 units sulfated insulin before breakfast and 35 units sulfated insulin before supper. Since discharge diabetic control has remained excellent and the dose of sulfated insulin has gradually declined so that she now (April 26, 1967) takes 20 units before breakfast and 20 units before supper.

Summary

Diabetes mellitus includes a spectrum of physiologic abnormalities which are characterized by an otherwise unexplained defect in glucose tolerance and beta cell decompensation. The beta cell mass, extractable insulin of pancreas, and levels of insulin activity in acid alcoholic treated serum are subnor-

mal. The ability of beta cells to respond to metabolic stress is probably severely limited. Knowledge of beta cell metabolism, renewal, and growth needs to be expanded. None of the theories which identify the onset of diabetes with a primary defect outside the beta cells are convincing in the light of current experimental evidence. Destruction of the islets by an infection or an autoimmune process are possibilities that deserve further study. The most impressive recent therapeutic advance in diabetes has been the development of sulfated insulin for the treatment of immunologic insulin resistance.

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PEDIATRICIANS' SPRING SESSION TO BE HELD IN ATLANTA

Closed-circuit television clinical presentations, a diversified scientific program, and approximately 100 scientific and technical exhibits will highlight the American Academy of Pediatrics' annual spring session, March 18-20, which will be held in Atlanta.

More than 3,000 pediatricians, their families and guests, are expected to attend the meeting in the Regency-Hyatt House.

Television presentations will cover subjects including newer diagnostic laboratory techniques in immunology and infectious diseases, physical clues in the diagnosis of disease, and the practical management of the child with chronic lung disease.

The scientific program will provide general session presentations on such subjects as the current status of virus cancer relationships, the diagnosis and management of the child who is too short or too tall, the obese child, advances in therapeutics, current status of radioisotope scanning in children, and recent advances in the diagnosis of cystic fibrosis.

The Academy, headquartered in Evanston, Ill., is the Pan-American association of physicians certified in the care of infants, children, and adolescents. It has more than 10,000 members in the U.S., Canada, and Latin America.

Statistically it would be reasonable to assume that the surgical approach is preferable to the non-surgical treatment.

Five Year Experience With Intracranial Aneurysms

LOUIS A. HAZOURI, M.D., *Columbus*

NINETY-SIX REVIEWED ANEURYSMS were seen within the last five years. This group of patients consisted of all aneurysms seen in three hospitals, on the free and private services.

There is much written in the literature as to the various methods of treating an individual with a subarachnoid hemorrhage with and without a proven aneurysm. Watchful expectancy with supportive therapy is one method; the other method is surgical, either by direct attack on the aneurysm itself or extracranial major vessel ligation. The aneurysm itself, of course, can be treated by direct obliteration, reinforcement by packing using plastic derivatives, muscle stamps, intraluminal coagulation with metal dust, extraluminal thrombosis with introduction of foreign bodies such as thistles, and so on.

Patients who were suspected of having an aneurysm with or without subarachnoid hemorrhage were placed on complete bed rest with a baseline pressure reading being taken. Laboratory studies, especially relative to a bleeding diathesis, as well as serology, blood sugar, cholesterol, urea nitrogen were also obtained. If the patient did not appear to be in any undue stress, x-rays of the skull and chest were made with careful attention to avoiding any undue strain to the patient. A lumbar puncture was then performed subsequent to which bilateral percutaneous carotid arteriograms were performed. If the angiograms proved to be negative, vertebral angiography was performed by way of femoral catheterization. Four vessel angiography was employed in those individuals who had multiple aneurysms.

Sedation as well as hypotensive agents were used. Originally hypothermia was utilized for massive subarachnoid hemorrhages. Our results with hypothermia have not been very impressive and as a result we have abandoned this method and have used only a mild degree of depression of the patient's temperature. This was obtained by the judicious use of sedation, ice packs as well as the Thermo-rite blanket.

Angiography was usually performed within five to seven days subsequent to the initial insult. Those individuals in which an intracerebral hematoma was suspected usually had arterial outlines performed in twenty-four to forty-eight hours.

Surgical Approach

The size, location and basic anatomical structure of the intracranial vascular tree as well as the degree of neurological involvement were taken into consideration as to the basic approach for therapy from a surgical standpoint. In those cases with fetal trifurcation, no extracranial vascular occlusion was carried out. The procedures employed were those primarily related to those of the Crutchfield arterial occlusion clamp as well as the match stick occlusion technique. The direct intracranial approach was predicated by the size of the lesion, its location and the inherent risk of compromising the patient's state. The procedure used here was either that of shriveling the aneurysm with a low voltage cutting current, or intentional rupturing of the aneurysm with cauterization and clipping. Packing of the aneurysm with gelfoam, fascia and muscle stamps has been most satisfactory in my experience for reinforcing the aneurysm. Plastic materials have been used on only one occasion by me with satisfactory results to date.

Careful fluid balance has been utilized post-operatively. Near catastrophies have been incurred by chemical imbalances of potassium, sodium and chloride. Carbon-dioxide-oxygen inhalation has been

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carried out in those individuals who have had extracranial carotid ligation. Peripheral vaso-dilators, in my experience, have been equivocal.

Ninety-six Patients Treated

Ninety-six patients were treated in this period, of which sixty were female, thirty-six male. The youngest was twenty-one years of age; the oldest, seventy-one.

There were sixty-five internal carotid artery aneurysms, ten aneurysms of the anterior cerebral artery. Anterior communicating aneurysms numbered nine. There were eighteen aneurysms involving the middle cerebral artery and seven aneurysms involving the posterior communicating artery. There were no aneurysms involving the vertebral or basilar artery in this series.

Of these ninety-six patients, twenty-four expired. A mortality rate of twenty per cent was found with internal carotid artery aneurysms, fifty per cent with anterior cerebral artery aneurysms, forty-five per cent with anterior communicating artery aneurysms, sixteen per cent with middle cerebral aneurysms. A total of fourteen per cent of those aneurysms involving the posterior communicating artery expired. In this group of ninety-six patients, seventy-four patients were treated surgically. Twenty-two cases were treated with symptomatic watchful expectancy.

Non-Surgical Group

Of the non-surgically treated group, eleven died for a total of fifty per cent. The distribution was as follows: two involving the anterior cerebral artery, two involving the anterior communicating artery, three involving a combination of both internal carotid artery, middle cerebral artery and posterior cerebral artery aneurysms, and four involving the middle cerebral artery.

Of the seventy-four patients who were treated surgically, a total of thirteen patients died for seventeen per cent mortality rate. A total of forty-one ligations was carried out on this group of patients exclusive of an intracranial approach. Thirty-five of these patients are living. Six have since expired for a survival rate of eighty-five per cent to date.

Of those individuals who had a direct intracranial approach with or without an extracranial carotid ligation, twenty-six were living and seven expired, with a survival rate of seventy-nine per cent. In the above experience, it would become apparent that the death rate without surgical treatment is some fifty per cent and with treatment eighteen per cent.

On comparing our statistics with the general literature, those patients surgically treated seemed to fare at a better rate. In those patients who were not treated with surgery it was noted that a survival rate of fifty per cent was present as compared to thirty per cent on a national level. I cannot explain this discrepancy other than if one were to compare various small series such as this, I am certain that it would be validated on a limited degree.

There were six intracerebral hematomata in this series. Three were associated with an aneurysm of the anterior cerebral artery, one with middle cerebral artery aneurysm, one with a posterior communicating artery aneurysm and one with an internal carotid artery aneurysm.

Duration of Illness

The shortest duration of illness for this group consisted of six hours to as long as three months with twenty-three of the patients dying within the first week. No attempt was made to grade these patients on a one to four basis as used in the national comparative study of intracranial aneurysms and subarachnoid hemorrhage. An arbitrary generalization was used by me. Individuals with extraocular muscle involvement, headaches, minimal subarachnoid bleeding with or without mild hemiparesis were taken into one group. Those individuals with a profound neurological change manifested by a massive subarachnoid hemorrhage with deep stupor, including multiple neurological deficits were categorized into a second group. There were forty-two in the simple group. In the profound group there was a total of fifty-three. No further breakdown was made for fear of making this a rather burdensome statistical paper. It was noted, however, that approximately forty per cent of these patients were hypertensive. Blood cholesterols were taken on all patients and only five cases were noted to have hypercholesteremia.

For those of us who are in private practice and have an opoprtunity to present a paper such as this, the rewards are an agonizing reappraisal as to the basic approach in the treatment of this complex problem. Treating these patients is an ordeal in its own right. Finding the right time, the right surgical procedure and accomplishing the best results remains an enigma. The surgical versus the non-surgical treatment remains controversial in some circles.

Statistically, it would be reasonable to assume that the surgical approach is preferable. The type of surgical approach again depends on the individual. As for myself, I feel that the procedure to be carried out is the procedure that you feel is the safest for the patient and the one which you are most comfortable in doing.

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MEDICAID: HOW IT AFFECTS YOUR PRACTICE

The practicing physician has long found it necessary to provide his services to many patients who need medical care and are not able to pay for the services. Now, through MEDICAID, there is a partial solution. Under this program, any licensed physician may receive his usual and customary fee for services provided to a MEDICAID patient subject to limitations of the state plan, according to the Georgia Department of Public Health, the state administrative agency.

ELIGIBILITY: All recipients of state public assistance payments are eligible. In addition (1) individuals under 21 who, except for age or school attendance, are eligible for AFDC assistance, (2) individuals residing in medical facilities who, if they left the facility, would be eligible for public assistance, and (3) those who would be eligible except for durational residence requirements that limit state assistance are also, by law, eligible for MEDICAID payments.

SERVICES: Nine items of medical services to the categorically needy are covered by the MEDICAID plan in Georgia. They are:

1. Inpatient hospital services (excluding institutions for tuberculosis or mental diseases). For persons 65 and older who are eligible for *Medicare* benefits, deductibles and co-insurance up to 90 days are covered. For others, coverage is up to 30 days per admission, with extensions preauthorized on the basis of medical necessity.
2. Outpatient hospital services that are diagnostic, therapeutic, or rehabilitative.
3. Laboratory and X-ray services.
4. Skilled nursing home services (excluding institutions for tuberculosis or mental diseases) for individuals 21 and older.
5. Physicians' services, wherever provided.
6. Home health services up to 100 visits per calendar year.
7. Whole blood—three pints for hospital inpatients.
8. Prescribed drugs and supplies, according to the Medical Assistance Drug List.
9. Also included are other medical services defined in Part B of Title XVIII (MEDICARE):
   a. Services and appliances incident to treatment, including surgical dressing, splints and casts, medications which the patient cannot take himself.
   b. X-ray, radium and radioisotope therapy.
   c. Rental of prescribed hospital beds, wheel chairs, oxygen tents and iron lungs for use at home.
   d. Ambulance service when other transportation is not feasible.
   e. Artificial limbs, eyes, braces and other prosthetic devices.

PAYMENT: Payments are based upon usual and customary fees and are verified by the Traveler's Insurance Companies. MEDICAID bills should be submitted on the MEDICAID forms and mailed to the designated intermediary offices. Payments of claims thus submitted will be made by the State Health Department on a monthly basis.

INFORMATION: Necessary forms, instructions and general information regarding the MEDICAID program may be obtained from the Branch of Medical Assistance, Georgia Department of Public Health, P.O. Box 38095, Atlanta, Georgia 30334.

Experience with a coronary care unit in a 195-bed community hospital is described and discussed.

Coronary Care Units in Small Hospitals

GOODLOE Y. ERWIN, M.D., *Athens*

Coronary care units are now being established in small general hospitals as well as the larger medical centers. Although there are admittedly many problems in maintaining such units in small hospitals, none are insurmountable. This paper will deal with some of these problems and how they have been handled at the Athens General and St. Mary's Hospitals in Athens, Georgia, serving a population of 100,000. It will also review the therapeutic approaches to the treatment of acute coronary disease as practiced in such units. Many of these principles are easily applied to the coronary patient treated in hospitals without such units.

Organization

A four-bed coronary care unit was opened as part of a sixteen-bed intensive care unit in Athens General Hospital (195 beds) in September 1965. All beds in the unit are private, air-conditioned rooms with glass panels allowing direct vision of the patient from the monitoring console in three of the four beds and indirectly through a large mirror in the fourth.

A bedside monitor with a five-inch oscilloscope, rate meter and demand pacemaker (American Optical Cardio-Care Unit) is mounted at the head of and to the side of each bed, out of sight of the patient. A five-inch oscilloscope is essential to easy viewing in an emergency situation. The pacemakers have rarely been used. Initially a patient cable with five electrodes was attached to the trunk of the patient. Now a cable with only three reservoir type electrodes (Sanborn) is used and fewer false alarms are noted. At the console facing the coronary beds, two twin beam oscilloscopes are mounted with one direct writing recorder. A memory loop is installed but rarely used. The equipment has been satisfactory.

Seven different internists have treated patients in the unit, which is under the jurisdiction of a committee. The chairman of the committee has the responsibility for administration and in-service training. Before starting operations, two nurses were sent to the Miami Heart Institute for one week of orientation. Since that time nurses have been trained with in-service teaching programs.

Most Physicians Admit Directly

Admission to the unit is left up to the individual physician. Most physicians admit all suspected cases of acute coronary disease directly to the unit. Others do not. Any patient with a suspected diagnosis of acute coronary disease may be admitted to the unit. Seventy-three per cent of the patients so admitted prove to have acute myocardial infarction. This term includes subendocardial myocardial infarction (characterized by typical symptoms of substernal chest pain along with serial electrocardiographic S-T and T-wave changes), and transmural myocardial infarction (characterized by the typical history, serial enzyme elevation and Q-waves on the electrocardiogram). Cases of acute coronary insufficiency are frequently monitored for a few days but were not included in the mortality statistics.

Eleven female patients with age range of 45 to 84, with a mean age of 69, are included in this study. Forty-five male patients with age range of 30 to 76, with a mean age of 56, are included.

Results

A reduction of mortality was achieved in the first year of operation of the Athens General unit. In the year beginning October 1, 1964, through September 1965, prior to the opening of the unit, the mortality rate for 56 patients with acute myocardial infarction was 31 per cent. This was comparable to the usual mortality rate found in large general hospitals.[1] During the first 15 months of operation of the

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From Coronary Care Committee, Athens General Hospital and St. Mary's Hospital, Athens, Georgia.

coronary care unit, the hospital mortality of 56 patients with acute myocardial infarction treated in the unit was 16 per cent. Only one case of unexpected cardiac arrest (electrical failure or primary derangement of the heart beat) in the absence of "pump failure" occurred in this 15 month period.[2] This patient was successfully resuscitated and left the hospital, and has now returned to work. As of October 1, 1967, there have been no deaths due to unexpected cardiac arrest in the unit at Athens General Hospital. Heavy emphasis has been placed on early treatment of arrhythmias since opening of the unit. No hospital deaths occurred after discharge from the unit.

At times the coronary care unit has been empty and on occasions has been filled. We would have difficulty staffing our unit if it were not part of an intensive care unit. There have been numerous staffing problems arising from turnover in nursing personnel. (Athens is a university town with many nurses being students' wives.) It has been necessary to have continuous in-service training programs going on at one or the other of the two hospitals in Athens alternately or at both simultaneously. The nurses are now being trained in electrical defibrillation. Previously this function was performed only by staff physicians and emergency room physicians.

Nurses Trained

In our training program, we have used Meltzer, Pinneo and Kitchell's *Intensive Coronary Care: A Manual for Nurses*[3] as our basic manual for the unit. The film "Disorders of the Heart Beat," available from local heart associations, is an excellent teaching aid. A set of EKG self teaching slides produced by Tampa Tracings has also been helpful. The nurse trainees are taught only the genesis of the EKG and arrhythmias. They are taught not to bother with patterns of infarction and T-wave changes.

In our situation it is difficult to use animals to practice defibrillation. We use a beef heart for our training sessions. The director of nursing education at each hospital runs a continuous program on cardio-pulmonary resuscitation with the help of physicians. Twice a year at staff meetings, we have a review on cardio-pulmonary resuscitation for the entire physician staff of the hospitals.

Coverage for Unit

Full time physicians cover the emergency room at both hospitals and are on emergency call for the entire hospital. However, when emergencies have arisen in the coronary care unit, our "code 99" procedure has usually produced a member of the active staff on the scene within a few minutes. There have been times when we have not had adequately trained nurses covering the unit, but we have had registered nurses in the unit at all times. When they are going through early training sessions, we tell them to ask for help when any irregularity is noted on the cardiac monitor. Our nursing supervisors at both hospitals are quite capable of covering the situations. Free and open communications between attending physicians and nurses are continually stressed.

Transvenous pacing has not yet been performed in our hospitals because of the previous absence of a physician skilled in placing catheters. However an eighth internist has now been added to our staffs who is skilled in this technique, and transvenous pacing can now be carried out. External pacemakers are available but have been used only a few times since the unit has been in operation. These have met with only limited success because of the traumatic nature of external pacing.

Length of Stay Varies

Length of stay in the unit is left up to the attending physician. Uncomplicated cases of acute coronary insufficiency usually stay three days. Subendocardial myocardial infarction and transmural myocardial infarction usually stay five to seven days. Complicated cases stay as long as necessary. It is rare for a case to stay over two weeks in the unit. There has probably been under-utilization of the unit. Very few patients have been admitted who did not have some form of cardiac disease. Admissions include cases of cardiac arrest from operating room, acute pulmonary edema, pulmonary emboli and respiratory acidosis.

Second Unit Opened

In March 1966, a second coronary care unit was opened in the other community hospital in our area, St. Mary's, a completely new 138-bed general hospital. A two-bed coronary care unit with similar equipment was opened in a ten-bed intensive care unit. The seven physicians that have staffed the Athens General Hospital unit also serve this unit and an eighth has recently been added. All nurses on this unit are being continuously trained by the in-service training program given by the internists on the staff. Good rapport between nurses and physicians has been a beneficial by-product of these training sessions given in small groups.

When the unit has had patients in excess of the number of monitored beds, the cardioverter or monitor from the operating room has been used temporarily.

It is foreseen that there will be more utilization of the units in the future. Two additional beds are planned at Athens General Hospital and two addi-

tional monitor-oscilloscopes have been ordered for St. Mary's Hospital.

Deaths

Case # 1. Eighty-year-old female admitted to coronary care unit on 10-8-66, with chest pain of three days duration and congestive heart failure. Patient expired on 10-9-66, with congestive heart failure.

Case # 2. Fifty-five-year-old male admitted to the medical floor on 11-2-65. Patient was transferred to the coronary care unit on 11-3-66, in congestive heart failure. Patient expired on 11-5-66, with congestive heart failure.

Case # 3. Sixty-one-year-old male admitted to coronary care unit in acute congestive heart failure on 11-12-65. Patient expired on 11-15-65, with congestive heart failure.

Case # 4. Eighty-four-year-old female admitted to coronary care unit on 1-13-66, with severe chest pain and shock. Blood pressure on admission was 70/40. Patient expired on 1-14-66, with intractable shock.

Case # 5. Seventy-year-old male admitted to medical floor on 4-28-66, in congestive heart failure. He was transferred to coronary care unit on 4-30-66. Patient expired on 5-2-66, with shock and congestive heart failure, complicated by pulmonary emboli.

Case # 6. Seventy-year-old male admitted to general medical floor on 5-27-66, and transferred to coronary care unit on 5-29-66. Patient died with shock and congestive heart failure on 5-30-66.

Case # 7. Fifty-eight-year-old male admitted directly to coronary care unit on 6-4-66, with severe substernal pain and congestive heart failure. Patient had old inactive tuberculosis and pulmonary emphysema. Patient expired on 6-7-66, with congestive heart failure.

Case # 8. Sixty-year-old male admitted to coronary care unit on 10-16-66, with severe pain and shock. Patient had had three previous myocardial infarctions. Patient died in shock two and one half hours after admission.

Case # 9. Fifty-seven-year-old male admitted to coronary care unit in circulatory collapse on 11-25-66. Patient died one hour later. Patient had had two previous myocardial infarctions.

Unexpected Cardiac Arrest

My experience in four consecutive cases of unexpected cardiac arrest is as follows:

Case # 1. A 61-year-old white male professional man was admitted to Athens General Hospital on 3-21-66. On 3-24-66, while I was present on the unit attending another patient, this patient went into ventricular fibrillation. Cardio-pulmonary resuscitation was started immediately and a 200 watt-second shock was given with no success. A second direct counter-shock of 400 watt-seconds terminated the fibrillation. He was mentally confused for a few hours afterwards but alert the next day. The patient had no further complications and was discharged from the hospital on 4-18-66. He subsequently returned to full-time work and is in good health.

Case # 2. Patient was a 58-year-old white male executive admitted to St. Mary's Hospital on 5-26-66, with acute myocardial infarction. He had a stormy course characterized by 2:1 A-V block, congestive heart failure and mental confusion. On 6-16-66, while I was in my office I was called and told that the patient had developed ventricular tachycardia. The nurses were instructed to set up for defibrillation. I was in the unit within 10 minutes. As I walked into the unit, the patient went into ventricular fibrillation. He was defibrillated with 400 watt-second counter-shock but had asystole. Cardio-pulmonary resuscitation was carried out. Intracardiac adrenalin restored the heart beat. The patient was mentally confused for several days thereafter but later made an uneventful recovery and is now in good health.

Case # 3. Sixty-year-old white male admitted to St. Mary's Hospital on 8-16-66. The patient had had a previous myocardial infarction. I was called and told that he was in the emergency room with pain in the chest. He was given an injection of meperidine and atropine, and sent straight to the coronary care unit. I arrived at the unit at about the same time the patient was being placed in bed. Before the electrodes could be attached, the patient had a convulsive seizure and cardiac arrest. Cardio-pulmonary resuscitation was started. I immediately gave a 400 watt-second counter-shock before an EKG was obtained. The patient revived and made a good recovery in spite of a compression fracture of the lumbar spine and a gastrointestinal hemorrhage from a bleeding duodenal ulcer during his convalescent period. The patient is now fully recovered.

Case # 4. The patient was a 45-year-old truck driver who had a myocardial infarction one year previously. He was brought to the emergency room of St. Mary's Hospital with pain in the chest of one-half hour duration. I was called from my office. The patient was given meperidine and an electrocardiogram was made. When I arrived on the scene, the patient had ventricular fibrillation. Cardio-pulmonary resuscitation had been started and a physician who had been present had already given one external counter-shock but had not relieved the ventricular fibrillation. Two succeeding counter-shocks were

successful in converting to a sinus rhythm. The patient made an uneventful convalescence and at the present time has good cardiac reserve and no cardiac enlargement. He is on a rehabilitation program.

Comment

The reduction in mortality and scarcity of cardiac arrest is achieved by prompt treatment of arrhythmias and prompt early treatment of congestive heart failure.[4] We have found that the most valuable drugs used in the treatment of myocardial infarction are lidocaine, atropine and rapid acting digitalis preparations such as lanatoside-c, and digoxin. Mercurial diuretics, isoproteronol and heparin are useful drugs. We feel that vasopressors are extremely dangerous drugs in myocardial infarction and they are used with great caution.

The psychological importance of relieving anxiety of the patient and the patient's family is stressed. One of the great benefits the patient receives in a coronary care unit is the psychological reassurance. Also of great benefit is isolating the patient from his family and other visitors. The family is usually quite emotional and can transmit a great deal of anxiety and fear to the patient. Only brief visits by the family are allowed. It has been found useful to give the family a copy of Prinzmetal's book, *Heart Attack: New Hope, New Knowledge, New Life*.[5] This keeps the family occupied, will help with education and rehabilitation of the patient, and gives a hopeful outlook.

Relieving Pain

We stress to the nurses the importance of relieving cardiac pain. We prefer that morphine sulfate or meperidine be used with atropine. Whenever intravenous morphine sulfate is given, we use atropine and keep levallorphan tartrate on hand in case of respiratory depression. In absence of respiratory depression, the nurses are instructed to use pain-relieving drugs as frequently as necessary to relieve cardiac pain. When pain persists, we search for extracardiac causes of chest pain. The most common cause of such pain is musculoskeletal pain of the shoulder girdle. Injection of lidocaine into the trigger areas in the pectoral, trapezius and rhomboid muscle groups will frequently relieve these bothersome pains. Pericardial pain is also very trying at times, but is usually relieved by use of hydrocortisone intramuscularly.

Refractory chest pain of cardiac origin is usually a sign of congestive heart failure. To find early signs of failure, it is advisable to have a chest x-ray performed on every patient. Whenever possible, we have the patient sit on the side of the bed and try to get a six-foot PA film or an approximation thereof. Interstitial edema or cardiac enlargement on x-ray is frequently found in the absence of rales. If there is any suspicion of heart failure, lanatoside-c or digoxin is given intramuscularly. If the patient has had no previous digitalis, one half of a digitalizing dose is given immediately and further increments are given every 2 to 4 hours depending upon response. It has been estimated that as many as 60 per cent of patients with acute myocardial infarction will have some degree of heart failure and will benefit by digitalis.[4] If the patient has been on oral thiazide derivitives, the potassium level should be checked and hypo-potassemia treated accordingly. Oral diuretics are avoided during the first two weeks of treatment because of electrolyte problems. Mercurial diuretics are more dependable and give fewer electrolyte problems. Pulmonary edema is treated with routine recommended measures. Phlebotomy is certainly useful. Automatic rotating tourniquets have been found very useful in our unit.

Lidocaine Treatment for Arrhythmias

The use of lidocaine in treatment of arrhythmias has been one of the dramatic advances in treatment of myocardial infarction. If any ventricular premature contraction or run of ventricular tachycardia is seen, the patient is immediately given 50 milligrams of lidocaine intravenously, and a drip of 500 milligrams of lidocaine in 500 ccs of 10 per cent glucose is begun. This is given slowly but is titrated to suppress all foci of ventricular irritability. We have been able to keep these drips going for several days at a time. A patient is able to tolerate 2 grams of lidocaine in 24 hours without difficulty. We have had no adverse reactions from lidocaine.

Congestive heart failure may be a cause of arrhythmias. Prompt digitalization with rapid acting preparations is indicated when this is found. Atrial tachycardias usually respond to digitalization. When only an occasional atrial premature beat is noted, we usually use quinidine orally. With nodal tachycardias and paroxysmal atrial tachycardia with block, we always are alert to the possibility of digitalis intoxication or hypo-potassemia and do not use lidocaine in such situations.

To prevent arrhythmias, we use reassurance of the patient, meprobamate, chloral hydrate and avoid caffeine. We rarely use barbiturates. These frequently cause mental confusion, may depress respiration and may depress the myocardium. Electrical countershock is reserved for arrhythmias refractory to drug treatment.

Sinus bradycardia associated with diaphoresis and hypotension is a dangerous situation and should be

promptly treated with intravenous atropine.[6] This situation is frequently encountered in inferior myocardial infarction with first and second degree heart block. First and second degree heart block are frequently transient disorders and will respond to drug therapy. In first and second degree A-V block following infarction we use atropine intravenously and subcutaneously. With progression or poor response, we usually give isoproteronol in a drip at a rate of 1 to 10 micrograms per minute. Two milligrams of isoproteronol are added to 500 ccs of 5 per cent glucose in distilled water. This is given at a rate of 10 to 15 drops per minute or at the slowest rate possible to achieve desired effect. This must be used cautiously as it may cause ventricular irritability. On the other hand, when the heart rate falls below a critical level, ventricular tachycardia and fibrillation frequently occur. We keep our defibrillator plugged in at the bedside in these cases. We have ceased to use the external pacemaker as it is too traumatic. In cases of asystole and Stokes-Adams attacks, we have been able to revive the patient with blows to the precordium and external massage. Occasionally intra-cardiac adrenalin must be used. In my experience, mechanical stimulation in this manner is more practical than external pacing. When third degree block is present, transvenous pacing should be used if available.

The absence of transvenous pacing should not deter one from opening a coronary care unit. The incidence of complete A-V block is less than 3 per cent. It has been shown that A-V block is frequently transient. It will sometimes respond to drug treatment and carries a mortality rate of approximately 20 per cent.[7, 8]

Hypotension vs. Shock

Our nurses are taught to differentiate simple hypotension from shock. In the past, many physicians were called and told that the blood pressure was low and they would thereupon prescribe an injection of a vasopressor drug. Such drugs are extremely dangerous in myocardial infarction. I have seen small test doses of vasopressors cause an unusual rise in blood pressure of 50 millimeters of mercury followed by runs of ventricular extrasystoles and ventricular tachycardia. If cardiogenic shock is suspected, lanatoside-c is given intramusularly to raise the cardiac output. An indwelling catheter is inserted to check the urine output. An intravenous of 10 per cent glucose is started. Two hundred ccs of this are given rapidly and response of the blood pressure and urine output is noted. A urinary output of 2 to 4 ccs per minute should occur in absence of shock. It is only after all of these measures are carried out that we may resort to the use of vasopressors. Central venous pressure has not been utilized at our hospitals.

Overweight Patients

Overweight patients are started on a liquid diet. Every attempt is made to remove as many pounds as possible while the patient is in the hospital. These patients usually remain on a liquid diet during their stay in the coronary care unit. After they are transferred to the floor, they are given a diet of 800 to 1200 calories. While on this diet they are instructed on the values of avoiding saturated fats and of using polyunsaturated fat.

We make every attempt to break smoking habits while the patient is in the coronary care unit. We treat the patient's agitation with meprobamate or amitriptyline HCl and occasionally keep oxygen going on a patient for a few days extra just to prevent him from smoking.

Many male patients become depressed during hospital treatment. Amitriptyline HCl is a very useful drug to combat this depression. When mental confusion and frank psychosis is present, thioridazine is used.

Conclusions

Our experience would indicate that it would be impractical for a coronary care unit to be maintained outside of an intensive care unit in a hospital of less than 200 beds. A possible alternative would be use of private rooms adjacent to the nurses station on a medical floor. To utilize personnel properly, hospitals with capacity of less than 100 beds should consider having an area composed of emergency room, recovery room and intensive care unit. Coronary care beds should be adjacent in private rooms if possible. This area could utilize highly trained personnel more efficiently with free interchange of personnel between these units.

The objectives of a coronary care unit are: (1) To prevent cardiac arrest by aggressive management of myocardial infarction and (2) To promptly resuscitate all patients who have cardiac arrest.[9] Our experience demonstrates that these objectives can be met in small community hospitals of between 100 and 200 beds.

D-C Defibrillator Mandatory

All hospitals that admit coronary patients or see emergency patients should have a D-C defibrillator with oscilloscope present in the emergency room. Many cases of cardiac arrest occur in the emergency room and can be resuscitated. The entire staff of every hospital should be trained in cardio-pulmonary resuscitation.

Many of the measures used in the coronary care

unit can be used to advantage in patients who do not have access to such units. Ventricular arrhythmias can be treated promptly with lidocaine. Every patient with myocardial infarction should have a chest x-ray and a diligent search should be made for signs and symptoms of congestive heart failure. When found, prompt treatment with rapid acting digitalis preparations should be instituted. Hypotension without shock should not be treated with vasopressor drugs. Sinus bradycardia and first and second degree A-V block should be treated with atropine and, if necessary, isoproteronol. Trained emergency resuscitation teams should be available to every patient with myocardial infarction.

GENERIC AND TRADE NAMES OF DRUGS

Meperidine (Demerol)
Lidocaine (Xylocaine)
Lanatoside-c (Cedilanid)
Isoproteronol (Isuprel)
Levallorphan (Lorfan)
Amitriptyline HCl (Elavil)
Thioridazine (Mellaril)

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THE NEW BIGOTRY

Practically everybody considers himself a "liberal" and practically every liberal condemns bigotry and prejudice. This phrase, "bigotry and prejudice," one must assume, refers to a general condemnation of an entire class based on a preconviction that the group is inherently evil. And no liberal would be caught entertaining any such "prejudgments." Not against any ethnic or religious group that is. But there is one field where the liberal may be prejudiced to his heart's content. That is in distrusting physicians. Here he may accept, as an article of faith, the thesis that physicians are inherently greedy and that all their opinions and actions are based on self-interest in the most unenlightened sense of that term. Indeed, it is even "smart" for the liberal to cling to such notions. Typically, he will reject the possibility that physicians, individually or in groups, are motivated by any honest dedication to public welfare.

If the doctor, for himself or as spokesman for a medical society, says that compulsory health insurance leads to second rate medical care, the prejudged answer snaps back: the doctor says that because he is prosperous under this system and doesn't want to reduce his income. If it is pointed out that the destruction of free choice removes something fine (and something therapeutically useful), the answer is that this is a myth dreamed up by physicians to protect their own interests.

Indeed, the "liberal" in such a context will not even concede that the physician might be honestly mistaken in his attitude. He will have it that the doctor takes this position out of greed, and deny that any physician who opposes expanding health insurance could possibly be honorably motivated. If you point out that physicians are forever doing things against their own interests, you get laughed at. If you dare mention the vast amount of gratis work done by every M.D., you are told that this is being patronizing, or that this is simply the result of a bad conscience. If you repeat stories of personal devotion, hours of unremitting and unrewarding vigil, or of personal exposure, you are told that this is pure corn.

No example of heroism, sacrifice, or selfless dedication to patients will make any difference. For the critic has already made up his mind. He has judged—indeed he has prejudged. And in the purest sense of the word, this is "prejudice." But it is the new prejudice, the permitted prejudice, even perhaps the fashionable prejudice. It is, furthermore, the safe prejudice, for the critics can be sure that no matter how hostile their tone, how unfair their condemnation, there can be no retaliation. For medicine's indispensable benefits are for friend and foe alike.

From the Journal of the Medical Society of New Jersey, December 1967

Effective therapy for three troublesome conditions is outlined.

Treatment of Some Common Skin Lesions: Plantar Warts, Epidermal Cysts, and Soft Corns

HERBERT S. ALDEN, M.D., *and* PAUL C. CRONCE, M.D., *Atlanta*

PLANTAR WARTS, EPIDERMAL CYSTS AND SOFT CORNS are encountered daily in dermatologic practice and are seen frequently in other types of medical practice. It is helpful, therefore, to have simple but reliable treatments for these three common skin lesions. We have found the following methods of treatment to be quite satisfactory and usually successful.

Plantar Warts

Recommended methods for removal of plantar warts are legion (see Table I). The variety of these methods indicates that no one is ideal or universally successful. In fact, in a recent statistical survey of plantar warts conducted by Barr and Coles,[1] "no treatment" or intelligent neglect gave a high percentage of successful results (97.1 per cent) in an unstated length of time. This is better than the *average* cure rate for warts, by most methods which is said to be 50 per cent. However, the majority of the patients in the survey of Barr and Coles were between ten and fifteen years of age and it is known that spontaneous cure occurs more often in children than adults.

We have had little success either with neglect or conjuration of warts on the soles or anywhere on the skin. We use a combination-type treatment which in the past six years has resulted in the cure of 98 per cent of 200 solitary plantar warts followed for two to four months after therapy. This procedure should be used only for single plantar warts with a diameter of 1 cm. or less. The technique can be used successfully on solitary large warts with little scarring, but healing may be prolonged.

The wart and the surrounding skin are first infiltrated with 2 to 6 cc. of 1 per cent xylocaine solution. It is best to use a 10 cc. three-ring control, luer-lok syringe for this purpose and continue infiltration until the surrounding tissue is blanched. The infiltration of anesthetic aids in the dissection and removal of the wart from the surrounding skin and also reduces the amount of bleeding.

Cold "knife" excision is then begun by using sharp pointed iris scissors to cut the stratum corneum and epidermis around the wart at a distance of at least 3 mm. from the visible wart border. A medium Piffard curette is then used to remove the entire wart with surrounding normal skin as an inverted cone. If the wart is not removed completely, any remaining downward projections can be removed by curettage of the base. Usually the entire wart can be removed without penetrating to the depth of the subcutaneous tissue. This "within-the-dermis" type of excision allows for healing from the lower portion of the dermis and sweat glands and thus decreases the amount of resultant scarring.

After removal, the surgical defect is usually painted with a saturated solution of trichloracetic acid to complete the therapy and obtain hemostasis. The treated site is then dusted with antibiotic powder (Neosporin) and bandaged with Telfa gauze. After approximately two days the patient is instructed to wash the area each morning and evening with 3 per cent hydrogen peroxide and apply antibiotic powder. The healing is seldom complicated by infection and is usually complete in three weeks. Post-operative

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pain is minimal and the patients usually have less discomfort during this period than they experienced with the wart. The resultant scarring is also minimal and causes no symptoms.

Epidermal Cysts

Another common lesion the dermatologist must permanently remove is the epidermal or keratinous cyst. These cysts can be found almost everywhere on the skin but are often located on or near the external ears and face.

A simpler, more rapid, and cosmetically superior procedure than excision and suture closure is drainage with avulsion of the cyst lining. After injection of a small amount of local anesthetic between the skin and cyst wall, the cyst is opened by electrocautery and its contents are expressed by pressure. A small curette (no larger than 2.5 mm in diameter) is then inserted and with the edge of the curette pressing against the cyst lining, a rapid circular motion is used to entangle the flaccid cyst wall on the curette. With this technique it is usually possible to avulse the cyst from the surrounding subcutaneous tissue and dermis and remove the cyst when the curette is withdrawn.

METHODS OF TREATING PLANTAR WARTS

Cryotherapy

(Solid carbon dioxide, liquid nitrogen, liquid air, and liquid oxygen)

Electrosurgery

(Electrodesiccation, electrofulguration, electrocoagulation, and surgical cutting current)

Surgery

(Paring, excisional surgery with sutures, excision surgery without sutures, curettage)

Local Chemotherapy

(Acids, podophyllin, cantharidin, formalin, various ointments and lotions, plasters, etc.)

Radiation

(Conventional x-ray, Philips contact x-ray, grenz ray, ultraviolet)

Ultrasound

Local Injections

(Vitamin A, iodobismitol, corticosteroids, etc.)

Oral Medications

(Vitamin A, Bismuth, Mercury, placebo, etc.)

Suggestion

(Hypnosis, psychotherapy, faith-healers, witch doctors, etc.)

No Treatment

TABLE I

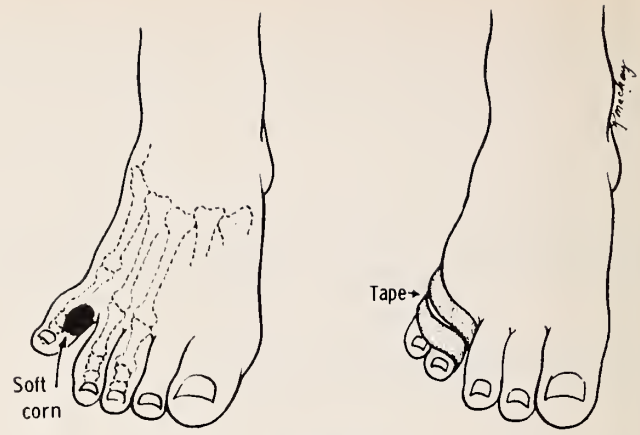

FIGURE 1

After avulsion of the cyst wall, final pressure is applied to the area to evacuate any remaining cyst contents and/or blood and a cotton swab stick dipped in an equal part, by weight, mixture of liquefied phenol, 70 per cent ethyl alcohol, and trichloracetic acid crystals is used to paint the residual cavity. Then one or more Terramycin Dental Cones are inserted. These cones help prevent infection of the treated site and seem to assist the eventual drainage and evacuation of any possible retained portion of the cyst or its contents. Healing is usually complete in 10-21 days and leaves a good cosmetic result.

Soft Corns

"Soft" corns are often difficult to manage and have a tendency to recur. They arise at sites of friction and/or pressure and are softened by the macerating action of sweat. Soft corns can occur between any of the toes but most commonly occur between the fourth and fifth toes, typically at the head of the proximal phalanx. These lesions frequently have an underlying bony spur or exostosis.

Movement of the toes against one another and/or pressure from shoes, increase the extent of corn formation and the discomfort. In many instances, therefore, "splinting" of the fifth toe with the fourth toe by means of tape, as shown in Figure 1, will relieve pressure, rubbing, and pain. It is wise to instruct the patient to clean the area with a brush and soap and water daily followed by careful drying and the application of an antibiotic powder (Neosporin) before retaping the toes.

Thirty to sixty days of this simple procedure often results in complete relief and sometimes cures. However, given the same shoes and the same walking habits, recurrence of the corn can, of course, take place.

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The Importance of the State Medical Journal to the Pharmaceutical Industry

C. JOSEPH STETLER, *Washington, D.C.*

LET ME MAKE IT CLEAR at the outset that the Pharmaceutical Manufacturers Association is agreed that the state journals *are* important to the drug industry as they play their special role of communication between an association and its members, between advertisers and readers, and sometimes between the association and other related groups. This fact is certainly reflected in the advertising support the journals are now receiving compared with a few years ago. I hope that our acknowledged respect for the journals has been partially responsible for this new trend. At the same time, I am aware that other elements have been primarily responsible for the change.

For one thing, as a number of our member firms are quick to point out, the journals themselves have awakened to the need to compete with new, attractive and effective national publications. The editorial content of the books has been upgraded; their appearance has been brightened; page sizes of a majority of them have been standardized, thus simplifying the purchase and utilization of advertising space, and most of the journals are now, I understand, represented by the Medical Journal Advertising Bureau in whose conference we are participating today.

May I also say that I am delighted to salute the Bureau on this occasion. It is a "working" organization able to study and demonstrate the performance of the journals, thereby providing advertisers with meaningful information on what their dollars will buy. By offering package transactions through the Bureau, the state journals facilitate space purchasing for advertisers, who otherwise would have to deal with each publication separately. By offering various placement combinations, the journals enhance their effectiveness in helping advertisers zero-in on particular areas of the country or particular groups of doctors.

Advertising Increasing

The added pages of advertising which each journal is winning can be attributed to the planning and combined efforts of all concerned. I understand, and am certainly glad to know, that the figures have climbed steadily over the past few years and are still going up.

It is apparent that if a quality publication is offered, namely a responsible journal that is respected and well read, and a real, professional effort is made to sell it, advertising can be obtained.

At the same time, I would urge each journal to make every effort to demonstrate to sophisticated advertisers that it is an efficient means of communication for drug firms to use. No matter how sympathetic an advertising manager may be to the desirability of supporting state journals, he must be able to prove he is placing his firm's material where it is being read. It is not too much to ask that you help him obtain that proof.

In preparing my remarks, I turned to the best possible authorities on the subject to find out why state journals are important to the drug industry. I asked the advertising managers of several of our member firms what induces them to use this medium; why do they think it is effective.

The answers were loud and clear. In the mounting barrage of medical communication hitting the doctor

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Presented at the State Medical Journal Advertising Bureau Conference, Chicago, Illinois, September 18, 1967.

Mr. Stetler is President of the Pharmaceutical Manufacturers Association.

from all sides, the state journal remains notable for its ability to cover the local scene. It provides the doctor with medical articles of special interest in his own area. Usually they are practical articles for the busy physician with new developments being discussed against the background of local conditions. The state journal also contains personal news about local physicians. This does not mean, I hasten to add, that these publications are regarded as merely gossip sheets. But they perform a proper function in reporting on the activities and accomplishments of doctors within the state which no national publication could possibly cover.

These are important considerations. They give the publications a built-in advantage which makes them uniquely attractive to their readers, and hence enhances their value as a vehicle for conveying an advertising message.

Of course, medicine varies subtly and significantly from state to state. Snakebite is a problem in Arizona; in Maine and Alaska, it is frostbite. The content of drinking water may be a matter of concern in Nebraska while physicians in Texas may be plagued by the problem of human botfly infestation. The industry has learned that drug sales reflect these variations; and while most of our firms do business nationally, their marketing problems are local.

Many manufacturers are depending increasingly on state journals, I am told, to help fill this local merchandising need. Evidently, the companies feel satisfied with the results, else the advertising growth I have mentioned would not be taking place.

Government Control Tightening

Overall, I believe the picture for state journals would be brighter if it were not for certain developments on the national scene involving government attempts to extend and tighten its controls over the entire drug industry and drug advertising in particular. New, stringent and far-reaching advertising regulations have been published by the FDA. Allowed to stand, they will have a profound impact on the delivery of product information to physicians. The form and content of drug ads would be drastically altered, adversely affecting their readability, thus reducing their value to physicians and the industry.

All medical publications, including those in which you are interested, have a heavy stake in the outcome of this controversy. This is a most appropriate gathering, therefore, before which to lay the more prominent facts today.

But first let me sketch the background briefly: Until 1962, legal restrictions on drug advertising were enforced by the Federal Trade Commission under statutory authority to prohibit false or misleading claims in all advertising. Drug firms were not singled out and required to include, or exclude, particular material, nor were they bound by government fiat as to how they might present their material.

In 1962, in the wake of the Kefauver investigations, Congress passed amendments to the Food, Drug and Cosmetic Act which have seriously affected everyone and everything having to do with drugs—whether it be publishing, research, discovery, clinical investigation, manufacture, promotion, distribution, prescription, dispensing or use. A relatively short provision was inserted in the legislation which permitted the FDA to require that each drug advertisement contain a true statement of information, in brief summary, relating to the effectiveness, side effects and contraindications of the advertised product.

As interpreted by the FDA, this apparently simple language conferred on the agency virtually unlimited powers over industry advertising. How unlimited, we are just beginning to see with the publication of the new regulations.

Now, what are the problems inherent in drug advertising and in complying with FDA regulations regarding advertising which have existed since 1963? Are drug companies openly ignoring a clear and simple mandate not to engage in false advertising by intentionally misleading the reader?

Not at all. In fact, a manufacturer may be in contravention of the complex requirements which are already in force, even though its advertising is neither false nor misleading, and even though every attempt has been made to follow the various complicated mandates.

"Fair Balance" Required

FDA's 1963 regulations, now in effect, require that "fair balance" be maintained in an ad's "brief summary" of the information on the effectiveness of the product and the information on side-effects and contraindications. Further, the present regulations require that the information concerning side-effects and contraindications appear in "reasonably close association" with information concerning effectiveness, and that it be given the "same relative degree of prominence" as the information concerning effectiveness, taking into account all the pertinent factors including typography, layout, contrast and other printing features.

Plainly, "brief summary," "fair balance," "reasonably close association" and the "same relative degree of prominence" are subjective terms. Two reasonable men may well differ, and quite honestly, on the conclusion reached when they apply these criteria to an ad.

But the nation has been led to believe that if the government reviewer's judgment differs from that of the company's medical director, the company per se is acting irresponsibly with a disregard for the public interest. That is the heart of the confusion and acrimony between the government and the industry over drug advertising which began with the original regulations almost five years ago. Now comes the FDA with even more complex and onerous controls over the form and substance of the industry's communications with the medical profession regarding its products.

Regulations Felt to Be Harmful

We question the proposed regulations' foundation in law in many respects. We strongly believe they are not constructive; to the contrary, our feeling is they carry the seeds of irreparable harm to the drug advertising industry and to a promotion and distribution system which has been the foundation for the astonishing drug progress realized in this country in the last 30 years. The system may not be perfect, but it is the best in the world.

If, in the future, creativity in advertising is to be discouraged, if ads are to be rendered verbose and hopelessly complicated, if manufacturers are to be limited by government decree to offering physicians dry and confusing reading in an intricate maze of statements, then advertising cannot achieve its purpose—either for the physician or the industry. Physicians will not read it and the industry will seek other means for providing the medical profession with necessary and meaningful information about available products.

It seems certain to us that the proposed revised regulations, published in May, will cut down the incentive and opportunities for advertisers to exercise creativity in producing attractive, effective messages which will capture the eye of the physician and call his attention to a particular product. It does not require an extraordinary imagination to picture the results after an ad has been put through the wringer of the arbitrary dicta which now loom over us. Further, it is obvious that, with the jumbling together of the favorable and adverse information on the product being advertised, the assimilation of the facts by the reader cannot fail to become a tedious and difficult process.

Why cannot the government, for once, proceed under the assumption that drug manufacturers, who value their names and reputations, are honorable and well-intentioned? Surely, well recognized, quality-conscious firms do not want to put out false or misleading advertising; indeed they cannot afford to. They have invested great amounts of effort and money in gaining their position in the drug field. What greater folly could there be than for them to risk it all through the deceitful promotion of one or two products? How long could they hope to remain pre-eminent in the eyes of the medical profession?

But FDA officials have chosen to ignore these considerations in their evident determination to lace a straight-jacket on the industry's promotion system. We realize we face a long round of time-consuming, patience-testing negotiations, extended hearings and, perhaps, a court battle before this controversy is resolved.

Before the screws are turned tighter on our industry by means of stringent new advertising regulations, we believe several very basic determinations must be made concerning the actual legal authority of the FDA in controlling the industry's promotion, and the nature and purpose of the promotion itself.

In some circles, the prevailing belief seems to be that prescription drug advertising is the *sole* or principal source of knowledge about drugs for the medical profession. It is frequently alleged that many physicians prescribe drugs on the basis of these advertisements alone. The drug industry disagrees. We believe that the primary purpose of an ad is to awaken the doctor's interest in the product, promote his further inquiries about it, and encourage him to prescribe it under the specified conditions.

Promotion Essential to Progress

The point here is—and this is basic to understanding the points at issue over drug advertising and appreciating their importance—that the drug industry's promotion and distribution system is essential to its continuing progress. It has been the cause, not the result, of mass production. And mass production has provided the resources for new drug development, yielding increasing benefits to mankind. It has also helped to bring about wholesale and retail price level declines in this period of inflation when the cost of most other commodities to the consumer has been going up.

Recognizing the crucial nature of this problem, the PMA has now sought, in the most direct way open to it, to demonstrate its good faith and its determination to safeguard and improve the high standards of drug advertising. The Association's Board of Directors has revised and strengthened the industry's own code which has covered ethical drug promotion practices since 1958.

We believe the new version, updated to meet the developing problems of the times, embodies a practical and responsible means for self-regulation by the industry of the advertising of its prescription products.

The code has been passed by the Justice Depart-

ment as to possible conflicts with antitrust laws, which as you know, is another form of government surveillance to which drug firms, in common with other industries, are subjected. As it now goes into effect, we believe it reflects the desire of member firms of the PMA to conduct their affairs in an entirely responsible way and to fulfill their obligations to the public without sweeping new controls over their affairs by the government.

Present Legislative Situation

Turning now briefly to other matters of transcendent importance to all of us here, I want to discuss the legislative situation in which we find ourselves—

The hearings on new drug legislation are being held in connection with the House-passed Social Security Amendments of 1967 before the Senate Finance Committee of which Senator Russell Long of Louisiana is chairman.

And the investigation of drugs and the drug industry is being conducted by the Monopoly Subcommittee of the Senate Small Business Committee under the chairmanship of Senator Gaylord Nelson of Wisconsin.

The two are tied together. Indeed, Senator Long, in addition to being Finance Chairman, is also a member of the Monopoly Subcommittee. He has served notice that he intends to incorporate the record of that Subcommittee's investigation, which has been palpably loaded against the industry, in the Finance Committee record to support his bill (S. 2299). This proposal would impose federal price controls on, and limit the number of, drugs which may be prescribed for beneficiaries of programs under various titles of the Social Security Act.

We are encouraged by the fact that several state journals, in common with other medical publications, have undertaken to awaken the medical profession to the fact that Congress is on the threshold of action on measures which would force drastic changes in medical practice when it comes to the prescribing of drugs. To those publications that have not carried articles or editorials on this important subject, I urge that you do so on your earliest publication date for the hour is late and the time is limited.

The words and the terms of the new bills may be different from bills introduced last year, but their aim is to accomplish the same naked objective. That is government control over the prescribing and dispensing of drugs, an assault on brand name products, and the placing of emphasis on drug prices, with quality and future drug innovation relegated to secondary consideration.

Many Questions Arise

The pending measures are complicated and raise many questions; questions over the selection of the drugs for the proposed national formulary; the propriety of forcing the use of generic terminology; the prospect of government price fixing of drugs; the adjudication of "acceptable quality" by a federal formulary committee; the reimbursable allowance for drugs and fixing the pharmacist's allowable professional fee, and the enormous administrative burden which would be imposed on the government through the preparation, printing and distribution of the formulary and price list which the bills envision.

Beyond these points, the bill would limit the drugs available to the elderly and financially unfortunate at government expense. At the same time, the whole range of the nation's drug armamentarium is available to other Americans. By the same token, these proposals place in jeopardy the historic right of the physician to determine his patient's precise treatment, the assurance to the patient that he will receive only the best and most suitable medicine to fit his individual need, and the future strength and viability of the drug industry itself.

Full-scale Attack on Industry

Nowhere is the purpose of these legislative proposals more clearly revealed than in the drug investigation by the Nelson Subcommittee. The testimony in these hearings has added up to a full-scale attack on the drug industry, with a constant playing on the theme that drugs bearing the same generic name are "therapeutically equivalent" if they meet minimum USP or NF standards, regardless of who produces them.

All of this, of course, is supposed to convince members of Congress and the public that generic prescribing is not only safe from a medical viewpoint, and a reasonable way for the government to hold down the cost of the health care it finances, but also is justified because of the unwarranted profits of the drug industry. Neither scientific data nor substantive expert testimony has been offered to support these allegations.

Freedom of Physician Jeopardized

Let me stress that there is more at stake here than the downgrading of an industry which has contributed so significantly to the sum of human progress over the last quarter of a century. There are scientific truths threatened with submersion under the tide of anti-industry propaganda. The freedom of the physician to exercise his judgment with-

out outside interference, the keystone of medical progress, is being placed in jeopardy.

I cannot emphasize too strongly the significance of these developments, not only to drug manufacturers, but to the medical profession and other allied professions and activities as well. If, as is now the case, the final record of the Nelson hearings is filled with distorted and biased material, it could become the foundation for the ill-conceived legislative action I have described. These are reasons why the record should and must be set straight in the public interest.

To this end, we have urged the medical profession throughout the country to join in expressing its opinion in unmistakable terms to the Subcommittee on the medical issues which have been raised in these hearings, based on the experience of physicians. We at the PMA have been encouraged to learn of the number of medical societies that have already submitted statements for inclusion in the record. Numbered among them are the foremost national organizations, as well as state and county groups. Also heartening has been the word that has reached us of the many individual physicians who have asked to be heard. Senator Nelson must soon decide to let "the other side" of the case be heard or to perpetuate what has been a one-sided, arbitrary set of hearings.

I suggest that the state journals can perform a distinct service in carrying the word to their readers of the importance of these efforts, and persuading even greater number physicians to make their views known to the public and members of Congress in our present extreme situation. I am sure I do not have to point out to you that the ability of medical publications to go on serving their societies could be seriously affected by the outcome of this struggle.

When the drug industry is accorded an opportunity to testify before the Nelson Subcommittee, perhaps next month, our intention is to interject some scientific truth and objective reason into the proceedings. But I will say quite frankly that the industry will have a difficult time defending itself and defending the interests of science unless some independent experts and medical practitioners are willing and given the opportunity to voice their opinions on the basic issues involved.

Both the doctors and industry, in our opinion, share the responsibility to oppose misguided actions which would harm both the nation's unrivaled health care system and this industry which has contributed so richly to medical progress over the years. Today, obviously, we have our hands full. But I have every faith, if we do our part, our cause will prevail. We will, of course, welcome your continued support in the period ahead.

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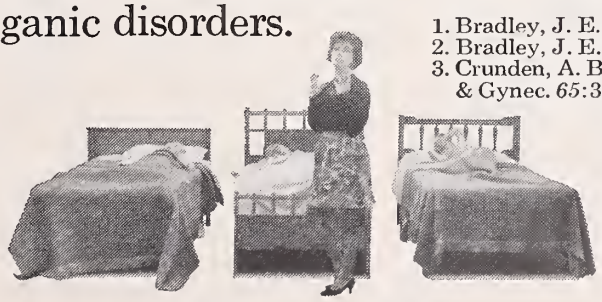

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Placenta Duplex

RICHARD TORPIN, M.D., *and* WM. E. BARFIELD, M.D., *Augusta*

Report of a case studied by reconstruction of the fetal sac.

Of all of the anomalous human placentas, the occurrence of two placentas with one fetus, more than any other, aroused the curiosity of the early obstetricians. Consequently there have been approximately 100 case reports of placenta duplex (dimidiata) during the past 150 years. Hyrtl, 1870, and Ribemont-Dessaignes, 1887, illustrated it in their atlases. Hohl, 1851, and Ahlfeld, 1887, as well as Ribemont-Dessaignes considered it to be a throwback to an earlier method of ovular decidual implantation. They cited the meager evidence in respect to the lower primate placentas, which even then were known to be double discoid especially in the monkey groups.

It is now known that the fertilized egg may lie between the two walls of the uterus, anterior and posterior, and then attach first to one wall and, a few days later, to the other directly opposite. It is also recognized that any primate on occasion may make use of a method entirely foreign to its usual custom. Thus monkeys characterized by double discoid placentas may have rarely only one placenta. This is known to exist in the macaques. Humans, certainly, and probably all of the one-disk-placenta higher primates may revert to the two-disk type of placentation.

Primary Disk Larger

Thus, as a rule, one disk (the primary) is usually larger than the secondary disk. Without doubt placenta succenturiata is of similar origin with the small disk on the opposite uterine wall. Placental bilobation almost always has one lobe anterior and the other posterior to the line of reflection of the two sheets of decidua upon each other.

According to the table of Wislocki, 1929, exceptions to the double discoid placentas occur in baboons, gibbons, orangutans, chimpanzees and gorillas which usually have a single discoidal placenta. Among the South American monkeys all have double discoid placentas with the exception of Alouatta (howling monkey) which generally has a single placenta. Since the observations in some instances are highly restricted in number, probably all of them, as does the macaque and the human on occasion, have deviations in this respect.

The Umbilical Cord Insertion

From evidence already accumulated in most of the monkeys (catarrhine and platyrrhine) the umbilical cord is inserted to the primary and larger disk, but not always. In humans, in a review of 75 instances of placenta duplex in the literature, about one third had the umbilical cord inserted on the larger disk and in two thirds the insertion was velamentous and usually to or near the membrane bridge between the two disks. The case reported here is unusual in this respect inasmuch as the umbilical cord was inserted into the membranes 15 cm distant from each disk and not to the bridge between. From this point one artery and vein branches proceeded to each disk. This is similar to one reported by Torpin and Hart, 1941, in which the site of the two equal disks was the same as in this case and the umbilical cord inserted into the membranes near the cervical opening to the uterus. Branches then traversed upward on the anterior walls of the membranes to the respective disks.

Barros, 1955, published the report of placenta duplex very similar to the one in this case report. The two disks in his case lay opposite to each other high in the uterus. They were almost equal in size and the umbilical cord inserted velamentously into

From the Department of Obstetrics and Gynecology, Medical College of Georgia, Augusta.

the membranes at one end of the bridge of the separating membrane. The total weight was 850 gm. In this case, he studied it by a sac distention method while it was suspended in a tank of water.

Holzaphel, 1898, was the first to demonstrate the exact distribution of the two disks in placenta duplex in the human. This he did by closing the delivery rent in the fetal sac and then distending it with water while it was immersed in a tub of water. However, several authors had suspected this arrangement from experience gained from manual removal of one of the lobes which may have been retained.

Case Report

The diagram in Figure 1 is drawn essentially to scale. It shows the outline of the distended fetal sac with the bisection into two halves, anterior and posterior, but identification as to which is which cannot be made. From the shape of the distended sac, the uterus at the time of delivery seemed to have had one horn more prominent than the other and the umbilical cord was inserted into the membranes near and slightly below it. The insertion was velamentous where it bifurcated, one artery and vein branches extending to each disk, 15 cm distant. No other fetal vessels coursed over other portions of the membranes. The diameters of the two disks are noted in the diagram. The larger one weighed 550 gm and the smaller 275 gm. The distance across the apically located membrane bridge varied from 3 to 6 cm. The drawing was made while the fetal sac was distended in water but the delivery rent in the sac was too large to allow measurement of the amount to fill the sac.

The Caucasian mother was 29 years of age and was attended by one of us (W.E.B.). She has two normal daughters, 4 and 6 years old respectively, and they were normally born at term. Three years ago she had her third pregnancy and at term was delivered of an anencephalic infant which died. This was her fourth pregnancy and in the later months she had weight gain and some degree of toxemia. She was considered to be not quite at term but the female infant weighed 8 pounds, 6¼ ounces. The husky infant was born from breech (RSP) presentation and had a single malformity; right harelip and cleft palate. There was no clubbing of the feet.

Clinically this type of placenta seems to affect the fetus in no wise differing from a single discoid placenta. In the older literature and prior to the use of antibiotics occasional maternal tragic results occurred when one disk was retained and removal was delayed or unsuccessful.

In the literature also are five or six publications in which the situation was clinically placenta previa. In these one of the disks was implanted or attached near or over the uterine end of the cervical canal while the other placental disk was higher up on either the posterior or anterior wall of the uterus. It has been thought that this type of attachment must have occurred in a markedly hyperflexed uterus. These then have the characteristics of other types of placenta previa which may deleteriously affect the fetus especially (as had occurred) in the rupture of one of the velamentous fetal vessels in the neighborhood.

In no other case of those in the literature was there found association with fetal malformity. There is no evidence that the fetal defect in this case was etiologically associated with this rare human placental formation which is common to the lower primates.

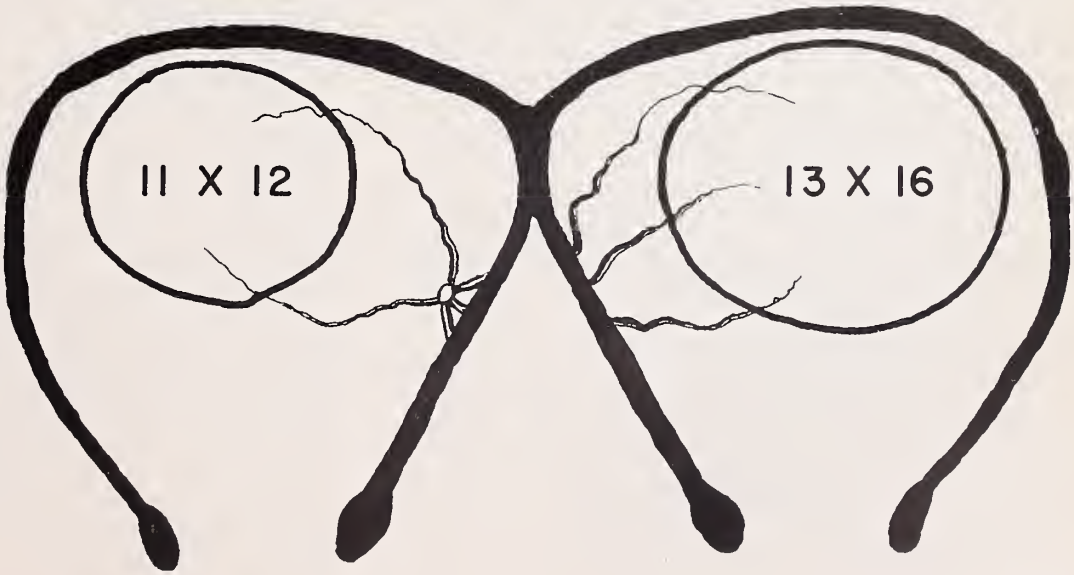

FIGURE 1

Outline of a reconstruction of the complete fetal sac. This has been laid open by an incision over the top and down the sides, leaving one area for a hinge, to show the anterior and posterior halves of the contents of the uterine cavity with the disposition of the two placental disks and the umbilical cord vessels. One uterine horn was more prominent than the other.

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75 YEARS AGO

OVARIAN CYSTS

J. M. SPENCE, M.D., *Waresboro, Ga.*

On or about May 1, 1890, I was called in consultation with Dr. W. P. Williams, of Waycross, fifteen miles west of Waresboro, and on our arrival we found a woman so large that we at once discovered the chair in which she sat must have been constructed especially for her. After resting sufficiently to give time for quieting the excitement caused by such an unusual sight outside of an exhibition (for she would have been the chief attraction of any show), we launched out on the history of her case. All of her ancestry were healthy, with here and there a tendency to scrofula, but not prevalent. Five years prior to our visit she gave birth to twins, attended, however, with great difficulty. An undergraduate M.D. attended her. Her health was apparently good, until becoming pregnant again, twelve months hence. The issue of this second pregnancy was triplets, again enduring a state of prolonged labor and excruciating pain, under the supervision of the same quack. In about two months something began to grow in the region of the right ovary. It grew rapidly for about three years.

She called several physicians, but failing to properly diagnose the case, they treated her for "Tape Worm" and all kinds of tumors. My associate, Dr. Williams, and myself made an examination with the utmost scrutiny, after which we introduced an exploring needle, which on its withdrawal, was found to contain a thick, dark straw-colored fluid, about the consistency of ordinary syrup. The legs and whole lower extremities, infiltrated with water, her tongue coated, and bowels costive. Infiltration caused by compression of the tumor on the kidneys and ureters. We next took measurement of the abdomen, which was six and one-half feet; and from the pubes to the ensiform appendix the distance was three feet and nine inches. From this can be drawn some idea in what shape this woman was.

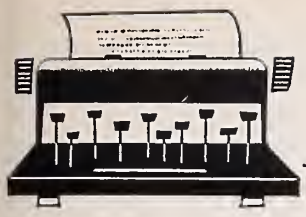
We gave her calomel, pulverized rhei, and carbonate of soda in repeated doses, together with iron, strychnine and digitalis for a few days. Delay was impossible, because death would ensue from compression before her system could be built up. Six days later we met and introduced a trochar and canula through the walls of the abdomen, and through the aperture thus made, there came (prepare to be incredulous) seventy quarts of this thick straw-colored fluid. The same treatment was continued at our second visit two weeks later, and at this time twenty-eight quarts of a similar fluid was drawn, together with something that looked like human brains. We left her evidently much improved, she being able to recline on a bed for the first time in five months. On the third trip, which was two weeks later still, we found her condition considerably improved, hence we again tapped, and this time drew thirty quarts of similar fluid, but the trochar would frequently become choked with the brain looking matter discovered after the first operation.

None of the operations shocked her so much as the first, immediately after which we were fearful of fatal results from heart failure; but with digitalis and whiskey we were able to bring about a reaction. We strapped her abdomen with a large tail bandage seam to assist in retracting the abdominal muscles. Her surroundings were very meager, hence she could not be supplied with the needed nourishment, and, as it was a charity case, my associate and myself could not provide her with all she needed, though we did our best. In two weeks longer we hoped and intended to effect a permanent and radical cure, but ten days later the king of terrors approached and claimed his victim. At this juncture, when prudence was better than potions, her morbid appetite overcame her and the strong hand of cholera morbus seized her and suddenly rushed her into eternity.

Now, gentlemen, you can realize what an awful case this was. One hundred and twenty-eight quarts of watery fluid drawn from her in the space of six weeks or but little more, and a large amount yet in the abdomen. It is with more than usual pleasure that I note my brother, who so ably assisted in each of these operations, present to hear and, if necessary, verify my report of this phenomenal case.

May Heaven screen me from another experience like this until medical science shall provide an escape from such untimely suffering.

From Transactions of The Medical Association of Georgia, Forty-third Annual Session, 1892.



EDITORIALS

Military Medicare Contract Renewed

THE ASSOCIATION, though not without difficulty, has renewed its Contract with the Department of Defense to serve as the fiscal agent and administrator for the Military Dependents' Medical Care Act in Georgia. Just prior to the lapse of the old Contract in July 1967, and while negotiations for a renewal of the Contract were in progress, the Department of Defense ordered the Surgeon General of the Army to discontinue all contracts with state medical associations under the Act "in order to avoid any possible question of conflict of interest."

The Medical Association of Georgia responded to this action by explaining to the Department of Defense that the Association was not violating and could not violate any federal conflict of interest laws. In addition, the Association, sensing that the Department of Defense was concerned about the role of physicians in passing on whether fees were "usual, customary and reasonable," noted that any fiscal agent, such as an insurance company, would seek to use the Association's medical review committees for adjudication on fees and to use the Association's profiles concerning usual, customary and reasonable fees in the State. Finally, it was pointed out to the Department of Defense that the Medical Association of Georgia had administered the program for 11 years at a cost to the Government of $1.44 per claim—a lower cost than that of 26 of the 41 state agents.

Defense Department Accepts Arguments

The Department of Defense accepted these reasonable arguments, and on December 8, 1967, the Surgeon General of the Army was directed to negotiate a new Contract with the Medical Association of Georgia.

Thus, the 11 year record of service by the Medical Association of Georgia will be continued to the benefit of the Government and the military dependents covered by the Act. The Medical Association of Georgia feels that it has been of benefit to all concerned in the following ways:

1. The Association, as fiscal agent, has maintained an efficient minimum administrative overhead.
2. The Association has provided an effective channel of communication to physicians in Georgia in regard to the provisions of the program.
3. So that patients may readily secure health care, the cooperation of all physicians in Georgia has been gained.
4. By establishing liaison contacts with the military bases in Georgia, the Association has provided full information to eligible recipients.
5. The Association has served the best interests of the Act by utilizing medical review committees.

Francis Shackelford
Alston, Miller and Gaines
Atlanta

Dopamine—Clinical Applications of a Biochemical Precursor

DOPAMINE HAS BEEN KNOWN FOR YEARS as the biochemical precursor of norepinephrine, the neurotransmitter of the sympathetic nervous system. More recently, studies of dopamine localization in animal tissues have demonstrated some areas of higher concentration than would be expected if it were present solely as a precursor. The interesting hypothesis has been put forward that dopamine may be functioning as a neurotransmitter in the central nervous system.

Despite intense interest in the biochemical and possible physiological roles of dopamine, little was known of its pharmacological effects prior to studies carried out in our laboratories. Investigations utilizing dogs demonstrated that dopamine resembles other sympathomimetic amines in that it stimulates the heart by a typical beta-adrenergic mechanism and causes vasoconstriction of most arteriolar vessels by a typical alpha-adrenergic mechanism. In addition, however, dopamine was found to differ from other sympathomimetic amines by causing dilation of the renal vascular bed. The mechanism of this effect is not related to either alpha- or beta-adrenergic receptors (i.e., this vasodilation is not blocked by the administration of alpha- or beta-adrenergic blocking drugs).

Increases Cardiac Output

When dopamine is administered intravenously to normal human subjects, cardiac output increases and total peripheral resistance decreases, but unlike other amines with similar hemodynamic properties such as isoproterenol (Isuprel), dopamine can produce these changes without significantly affecting heart rate. Probably of more importance, infusions of dopamine consistently increase renal blood flow and sodium excretion in normal human subjects. Because of these hemodynamic and renal actions, dopamine was administered to clinically ill patients who would have been expected to benefit from an increase in cardiac output and renal blood flow. The first patients to be studied were a group of individuals with severe congestive heart failure, poorly responsive to digitalis or to diuretics available at that time (1963). Intravenous infusions of dopamine increased sodium excretion in each of these patients, and renal blood flow and glomerular filtration rate also increased in several patients in whom these measurements were made. Although dopamine was beneficial in these patients, its use is limited in chronic congestive heart failure because of the fact that it must be administered intravenously. We are currently searching for an orally absorbable dopamine analogue which would therefore have potential usefulness in the treatment of heart failure.

Used in Shock

A more practical application for dopamine resulted from investigations of the effects of the amine in patients with shock syndrome. Intravenous infusions of dopamine increased cardiac output, improved the peripheral circulation and restored urine flow in a number of patients with shock of various etiologies. In some of these cases, other sympathomimetic amines have previously proven ineffective. The evaluation of dopamine for the treatment of shock is continuing in our division and in several other academic centers as well. If unexpected toxicity does not develop and our initial results are confirmed, it is possible that the amine may be available for use by the practicing physician in the future.

More recently, studies in our division have suggested that dopamine may be a

useful adjunct in the treatment of severe phenobarbital intoxication associated with hypotension and oliguria. Laboratory experiments indicated that dopamine infusions produced marked increments in phenobarbital excretion in phenobarbital-intoxicated dogs. We have subsequently seen the same effect in a patient who had ingested an overdose of the barbiturate.

The investigations discussed above illustrate an important aspect of research in clinical pharmacology—the ability to study drugs in experimental animals, normal human subjects, and patients with disease. Increased emphasis is now being placed on the development of clinical pharmacology divisions in medical schools and hospitals. The support of such units has been made possible by the National Institutes of Health and contributions by private foundations such as the Burroughs Wellcome Fund and the Pharmaceutical Manufacturers Association. It is hoped that more young physicians will give consideration to embarking on a career in clinical pharmacology, since many well-trained investigators will be required to staff such units in the future.

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Emory University School of Medicine, Atlanta

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AESCULAPIUS AWARD HONORS OUTSTANDING SCIENTIFIC EXHIBIT

The Medical Association of Georgia, in cooperation with Mead Johnson Laboratories, takes pleasure in announcing the AESCULAPIUS AWARD, to be presented to the author of the most outstanding scientific exhibit shown at the 1968 Annual Meeting.

The scientific exhibits will be judged by a committee of the Association and the winner of the AESCULAPIUS AWARD chosen by them. The winner will be presented with a certificate, suitably inscribed with the title of the exhibit and the author's name, and will receive a $200.00 cash prize donated by Mead Johnson Laboratories. Presentation will be made during the convention.

Physicians interested in submitting exhibits for showing at the Annual Meeting should make application to Medical Association of Georgia, 938 Peachtree Street, N.E., Atlanta, Georgia.

CALL FOR SCIENTIFIC EXHIBITS

114TH ANNUAL SESSION OF THE MEDICAL ASSOCIATION OF GEORGIA

Augusta, Georgia, May 5-7, 1968

For Information and Applications, Write to:

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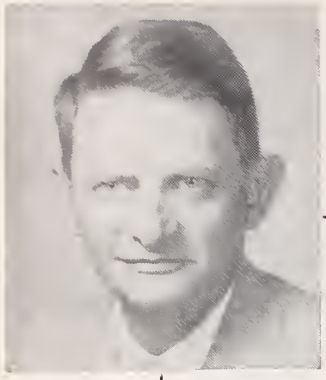

THE STATE OF MEDICAID

THE TRANSFER OF SO LARGE A STATE PROGRAM from one department to another was a Herculean task. To have this complicated by the addition of a new phase (Doctor Payment) further complicated the job. A new State plan had to be drawn, submitted to the Department of Health, Education and Welfare, and after approval by the "Feds," rules and regulations had to be promulgated. This was not difficult in the payment for hospital care and drugs because these phases were already functioning; however, the addition of doctor payment, payment for ambulance services and prostheses was not so easy. This situation necessitated hiring and training new personnel, designing and printing new forms, programming computers and other almost endless tasks, all of which caused delay. In the face of all this the Department of Health has done a magnificent job; however, I do not mean to imply that the job is completed.

Timing for Processing Claims

In order to understand better what to expect in the way of timing, some of the mechanisms involved in processing claims will be mentioned:

1. The payment for physicians' services has been scheduled to process checks once a month.
2. If a form is improperly completed and has to be returned or given special handling, this means a minimum delay of 30 days. If the form is returned to you and you delay 10 to 14 days in returning it, a 60 day delay could easily occur.

During November there occurred a computer malfunction that required about 10 days to rectify, and to compensate for this, three runs were made in December. Also, the changes in Welfare Rolls are not received until the end of the month. There are about 2,000 of these each month. Work is being done to rectify this situation.

Each form is processed for two types of information (payment and statistical). This procedure will be changed to process for payment prior to processing for statistical reports. This should result in less delay, but will not lessen the necessity that every form be complete prior to any processing.

In summary, every effort is being made to overcome the difficulties of a new program and to make prompt payment. However in this interim a great deal of patience will be needed.

John T. Mauldin, M.D.
President, Medical Association of Georgia

MAG REAFFIRMS SUPPORT OF CANCER SOCIETY'S ANNUAL EDUCATION FUNDS CRUSADE

A. H. LETTON, M.D., *Atlanta**

THE MEDICAL ASSOCIATION OF GEORGIA COUNCIL reaffirmed its stand in support of the American Cancer Society's Independent Education Funds Crusade when it approved the following resolution at its meeting on June 3, 1967:

WHEREAS the Council of the Medical Association of Georgia did approve in a meeting July 12-13, 1958, an AMA Resolution recognizing the importance of volunteer health agencies in the fields of public and professional education and research; and

WHEREAS the retention of their independent voluntary status was then stated to be of great importance in continuing their record of contributions to the health and medical care of the American people; and

WHEREAS the American Cancer Society, a voluntary health agency, does now conduct an annual independent EDUCATION Funds Crusade, during which the importance of early detection of cancer through regular cancer detection examinations is given paramount attention in the training of thousands of volunteer workers; and

WHEREAS the American Cancer Society reports that many of the 28,000 Georgians who have survived five years after treatment for cancer discovered their cancer in the early, curable stage as a result of their volunteer work in the Crusade;

THEREFORE: Members of the Medical Association of Georgia are urged to counsel and cooperate with the American Cancer Society to the end that Georgia's cancer death toll may be reduced in future years.

In December 1957, the House of Delegates of the American Medical Association issued a statement in which enthusiastic approval of the report of the Committee on Relationships between Medicine and Allied Health Agencies was recommended.

The report said, in part, ". . . As the Medical Society is dedicated to maintenance of health in the communities it serves, it has an interest in and an implied responsibility for citizen groups who have similar dedication. . . . Any agency that conducts health education, research and service becomes an object for Medical Society consideration."

In line with this recommendation the above cited resolution was adopted by the Medical Association of Georgia in 1958 and reaffirmed in June 1967.

* *Dr. Letton is Chairman, Professional Education Committee, Georgia Division, American Cancer Society.*

CONGENITAL RUBELLA SYNDROME: CARDIOVASCULAR DEFECTS

GORDON M. FOLGER, M.D., ***Augusta***

THE ABILITY OF THE FETUS to acquire active infection with rubella virus is firmly established not only on clinical grounds but virologic as well. Indeed, it is possible to recover rubella virus from the products of conception in approximately 50 per cent of women known to be clinically infected.

Infection of the developing fetus by the rubella virus is now universally accepted as a teratogenic event capable of, although not uniformly, causing deformities of the eyes, central nervous, genitourinary and the cardiovascular systems when its occurrence is consequent with embryologic development of those systems, i.e. the first trimester of pregnancy. Congenital deformities may be expected in approximately 10 to 30 per cent of infants following rubella-affected pregnancies. Intrauterine growth retardation is also a usual finding, with the involved infant generally being undersized for his gestational age. Active infection may be present at birth.

Vascular Structures Affected

Recent experience at the Medical College of Georgia, principally with affected children who are the result of maternal rubella infection during the epidemic of 1964, strongly indicates a highly significant teratogenic effect of the rubella virus on vascular structures contrasting somewhat with earlier reports indicating malformations of the heart as the principal defects. Indeed, the pulmonary arteries appear to be the most commonly affected cardiovascular structures with isolated or multiple coarctations involving the central as well as the more distal vessels occurring. Such stenoses have been encountered in nearly every affected individual with cardiovascular manifestations. Although extremely frequent, it is unusual to find these abnormalities as a cause of severe or symptomatic disease although they are usually the cause of prominent, widely distributed systolic murmurs. Patency of the ductus arteriosus has been encountered in slightly greater than 50 per cent of our patients. This abnormality, in contrast to pulmonary arterial stenosis, is usually highly significant with large left to right shunts culminating in congestive cardiac failure, a frequent occurrence. Small numbers of individuals, less than 10 per cent in our present series, have manifested stenosis in one or more locations in the systemic arteries, most commonly the supravalvular aortic area.

Abnormal Pulmonary Valve Common

The most common anomaly occurring at a cardiac level is abnormality of the pulmonary valve. This has occurred with a frequency of approximately 20 per cent and has exhibited a spectrum varying in severity from mild with little clinical significance excepting the murmur to total atresia of the valve resulting in cyanotic heart disease. With the exception of patency of the ductus arteriosus, shunting lesions are surprisingly uncommon. Ventricular septal defect, reported in the earlier literature as a common finding in infants with the maternal rubella syndrome,

has been encountered in only three of the 26 cases recently studied hemodynamically at the Medical College of Georgia. In two of these individuals, pulmonary valvular atresia was also present. Thus, only one patient has had a proven ventricular septal defect as a single lesion. This finding is consistent with more recent reports by other investigators. Gross atrial septal defects are uncommon, and no instance of this defect has been encountered in our series.

Pulmonary Arterial Stenosis

Comment need not be made on the clinical findings associated with the aforementioned defects, with the exception of pulmonary arterial stenosis, as they do not differ in the child with the rubella syndrome from those encountered in otherwise normal children. However, the features of pulmonary arterial stenosis are specific, have not been emphasized in standard texts and in our experience have contributed to the erroneous diagnosis of ventricular septal defect in these children. The murmur with this abnormality is audible precordially, is harsh and may be nearly holosystolic. Its typical feature is radiation to one or both axillae with an intensity closely approximating that heard precordially.

This type of murmur, though obviously not to the exclusion of murmurs of the other defects mentioned, when found in an infant or older child with a hearing defect, cataracts, mental retardation or combinations of these abnormalities should lead one to a consideration of the maternal rubella syndrome.

Department of Pediatrics
Medical College of Georgia

GEORGIA DIVISION, AMERICAN CANCER SOCIETY ANNOUNCES SERIES OF SCIENTIFIC SESSIONS ON CANCER

Dr. A. H. Letton, Chairman of the Professional Education Committee for the Georgia Division, American Cancer Society, has announced expanded efforts of this committee to provide physicians in Georgia with the latest developments of diagnosis and treatment of cancer.

Plans are under way for a major seminar on the subject to be held in Augusta, November 11, 12, and 13, 1968. In addition, a series of one-day short courses on procto-sigmoidoscopy and other subjects is being planned in various sections of the state.

Dr. A. B. Conger, Chairman of the Board of Directors of the Georgia Division, American Cancer Society, announced that the Muscogee County Medical Society and the Muscogee County Unit of the American Cancer Society have scheduled a short course on "Procto-Sigmoidoscopy" on March 22 at Callaway Gardens, starting at 9:30 a.m. This short course will be open to all physicians in Georgia, but is planned primarily for those within the 75 mile radius of Columbus.

Dr. Dan Sullivan, President of the Richmond County Medical Society, and a member of the Board of Directors of the Georgia Division, American Cancer Society, has announced that the Richmond County Medical Society and the Medical College of Georgia will serve as co-sponsors with the American Cancer Society for the major seminar in Augusta. The Savannah River Plant of the Atomic Energy Commission, the U.S. Army Hospital Specialized Treatment Center at Fort Gordon and the Veterans Hospital in Augusta are lending their support in developing the program.

Dr. Sullivan said, "We are planning to include subjects which will be of interest to all disciplines of the medical profession from pediatricians to general practitioners, and will bring together an array of nationally known specialists on the subjects. A detailed schedule will be issued as soon as plans are complete."

The first short-course was held on January 17 at Tift General Hospital in Tifton, Georgia. Dr. James Kirkpatrick was Chairman. Dr. John Wilson, Medical Vice President of the Georgia Division, American Cancer Society, presented the course on "Techniques of Using the 'Procto,' with Demonstrations." Dr. James W. Lea, hematologist at Emory, lectured on "Leukemia and Lymphomas," and Dr. Clayton Wood, a dermatologist in Albany, lectured on "Cutaneous Manifestations of Malignant Disease."

Dr. Letton said, "Other short courses will be developed as time and interest permit. Members of the Georgia Academy of General Practice who attended the Short Course in Tifton will receive four hours credit. Accreditation will be applied for all courses offered. Our purpose in presenting these courses is to bring the latest information to the doctor, rather than have him have to seek it elsewhere."

MEDICAL EDUCATION COMMITTEE

LAST DECEMBER 16, a Health Personnel Symposium was held at the Fulton County Medical Society Building to explore the feasibility of forming a Georgia Health Council which would serve as a coordinating body for the recruitment of medical and allied medical personnel.

More than twenty medical and health organizations were represented, many of which enunciated the degree of their participation in health careers recruitment. Following a lengthy discussion, the group unanimously voted to establish a Steering Committee for the purpose of forming a Health Council.

This is certainly a step in the right direction. Georgia is far behind in this effort, not only in the nation but in the South as well. Such Councils have long been in existence with full time staffs and adequate budgets in such states as Alabama, Virginia and North Carolina. This is not to say that Georgia has not been interested or has not done anything in this area. On the contrary, many of the states allied health groups have independently done extraordinarily well in recruiting within their own scope of interest.

In 1958, the Allied Medical Careers Clubs, Inc. was founded for the purpose of coordinating such activities. This organization has done a noteworthy job but the fact still remains that without a sizeable budget and full time personnel, the problem of inadequate recruitment will remain with us indefinitely.

Should the Steering Committee come forth with the proposition of founding a Georgia Health Council, the onus of funding such an agency will fall upon the Medical Association of Georgia as well as all other groups that expect to derive any benefit from the Council.

We need more physicians and we need more allied health personnel. It is the duty and indeed the obligation of MAG to take a leading role in seeing that this Council is properly financed and staffed in order to accomplish the ultimate.

J. Rhodes Haverty, M.D.
Chairman
Atlanta

JOINT MEETING OF MAG SPECIAL FINANCE COMMITTEE AND THE MAG HEADQUARTERS EXPANSION COMMITTEE

A joint meeting of the Special Finance Committee and the Headquarters Expansion Committee held December 9 resulted in the following recommendations to the Council:

1. That no action be taken by the Association regarding an increase in membership dues until such time that actual annual operating costs exceed annual income, or until projected programs are developed which indicate a need.
2. That the headquarters building not be expanded merely for the purpose of attracting tenants for rental income.
3. That needs for building expansion or changes to the existing facility based on the operating needs of the headquarters staff be studied by the new Executive Secretary and brought to the attention of the Headquarters Expansion Committee in January 1968.
4. That representatives of the Association, both from the membership and the staff, function in a manner befitting the stature of the Association.

These committees will continue to function and render reports to the annual meeting of MAG in May 1968. We will also recommend at that time that they be continued.

GEORGIA'S TWO PRONGED TREATMENT PROGRAM FOR MENTAL ILLNESS

REGIONAL STATE HOSPITALS FOR THE MENTALLY ILL

CHARLES K. BUSH, M.D., *Atlanta**

THE CONCEPTS OF DECENTRALIZATION and regionalization are the two prime movers which will bring better hospital care for Georgia's mentally disordered citizens:

—Decentralization of overcrowded Central State Hospital and Gracewood. With over 12,000 patients in these two hospitals, something has to be done to reduce the burden.

—Regionalization of mental health services to bring treatment and care closer to the home of every patient.

What is the State Health Department doing to bring about those concepts?

Part of the answer lies in the establishment of Regional Hospitals for intermediate and long term care of the mentally disordered. As recommended in the 1964 Comprehensive Mental Health Plan for Georgia, the State Board of Health has authorized the construction of eight to ten Regional Hospitals to be located in population centers where there are supporting medical facilities and professional personnel.

More Personalized Service

The establishment of Regional Hospitals is not an attempt to create "little Milledgevilles" around the state, but rather to bring more personalized services closer to the citizens. Central State Hospital has had up to 12,000 or more patients at a time. The new Regional Hospitals will never have more than 1,000 beds each, with the initial capacity being set according to the immediate need of the area involved and the money available at the time.

It is the intent of these hospitals to provide close-to-home care for alcoholics, the aged, the mentally ill, mentally retarded and emotionally disturbed children. Each hospital will consist of one "campus" with separate units for each disorder—each unit with its own program, building and staff. All units will be under one administration.

The buildings on the campus will be modern, one-story facilities set on a carefully landscaped site to make the hospital as "non-institutional" in appearance as possible.

Money Appropriated for Three

Money has been appropriated for the first three hospitals to be built in Atlanta, Augusta and Savannah. Ground was broken in January 1967 for the Atlanta and Augusta hospitals and work is expected to be completed in late 1968 or early 1969. The Savannah hospital will probably go out for bids in the spring of 1968.

Additional sites for hospitals selected by the State Health Board include Columbus, Rome, Albany, Gainesville and Macon. The construction of these will depend on available monies. Other locations will be included in future planning.

Basically, each hospital will have the same facilities with two exceptions: (1) the Augusta Regional will not have a retardation unit because Gracewood School will take that area's retardates, and (2) the Rome Regional will incorporate into its campus the state's tuberculosis hospital.

Financing of the hospitals will be entirely with state funds, and the hospitals will be under the supervision of the Hospital Services Branch of the Division of Mental Health.

* *Director, Hospital Services Branch, Division of Mental Health, Georgia Department of Public Health.*

COMMUNITY-BASED PROGRAMS FOR THE MENTALLY ILL

ILHAN M. ERMUTLU, M.D., *Atlanta**

THE AVAILABILITY OF MENTAL HEALTH SERVICES to the individual in his own community is the core of Georgia's mental health programming. To complement the Regional Hospital concept, the State Health Department, through its Division of Mental Health, has set up a Comprehensive Community Mental Health Program based on the ideas of early detection and treatment at the community level and aftercare and adjustment for patients returning from hospitalization to their home.

For many emotionally disturbed citizens, these community programs offer treatment in their own surroundings, and the patient's personal physician continues as part of the treatment team.

Six Basic Services

The Health Department's plan establishes six basic services in a community: in-patient and out-patient services; emergency care; partial hospitalization; aftercare; consultation and education services to medical and non-medical professionals on community mental health problems.

These planned programs currently fall into two major areas: coordination of community resources and the actual building of mental health centers.

There are now limited programs being operated by 29 county health departments which serve some 60 counties. There are nine communities which have written plans for centers. Macon, Athens, Jonesboro, Augusta, Valdosta and Thomasville have been approved for comprehensive centers. North Fulton county, Central DeKalb county and Gainesville have written plans for centers. Waycross has expressed interest in developing a center, and Savannah is reorganizing its resources to provide for a comprehensive community program.

Since a mental health center is community owned and operated, a community must be willing to spend some money to get it going and keep it going.

Federal Matching Grants

Currently, funds for construction of such centers are allocated on a 50-50 matching basis of local funds and federal grants. There are no state funds available at the present for participation in these projects. An original State Health Department request for $2.4 million to help in a three-way sharing of the cost was deleted from the Department's budget at the time of the last General Assembly. However, state funds are available for operation of community programs.

To carry out the community plan, the State Health Department works closely with interested citizens, local medical professionals and mental health associations.

It is encouraging to know that a number of Georgia communities have recognized the need for local mental health programs. Many of these communities are showing outstanding initiative and leadership in finding ways to establish these programs.

We in the Health Department are ready to assist any community in establishing a local program, but it's still really up to the community to get the program rolling and keeping it moving.

* *Director, Community Services Branch, Division of Mental Health, Georgia Department of Public Health.*

BIOMEDICAL COMMUNICATION GROUP STUDIES IN ATLANTA

Eight students from a variety of health and scientific fields are studying in Atlanta this quarter—they're the first class in a new graduate program in biomedical communication established by Congress in 1965 as one answer to the "information, knowledge and population explosions."

Their goal is to become specialists in the art and science of biomedical communication.

This quarter, the participants are attending classes and special training at Emory University School of Medicine, Georgia Institute of Technology and the National Medical Audiovisual Center.

The one-year course, leading to a master's degree of medical science in biomedical communication, began at Tulane University in September 1967. Following their Atlanta studies, the students will continue at the University of Nebraska in the spring; in the Washington, D.C., area in June, and next summer they will work on master's theses.

For Your MAG 1968 Annual Session
Hotel and Motel Reservations

APPLICATION FOR HOTEL AND MOTEL ACCOMMODATIONS
Medical Association of Georgia 114th Annual Session
May 5-7, 1968—Augusta, Georgia

A HOUSING BUREAU has been established for your convenience in making hotel and motel reservations at Augusta for the 1968 Annual Session of the Medical Association of Georgia. Comparable room rates and accommodation information are listed. *Use the Reservation Form below.* Please specify your first, second and third choice hotel or motel. All requests for reservations should give: (1) anticipated date and hour of arrival; (2) date and approximate hour of departure; (3) names and addresses of all persons who will occupy the accommodations. All reservations must be cleared through the Housing Bureau. Since all requests for rooms will be handled in chronological order, you should mail your application as early as possible to secure the accommodations you request. All reservations will be confirmed.

Augusta Town House: Broad at Albion St. (722-5541). **Single $8-12, double $12-18, $3 for extra person occupying room.** 100% Air Conditioned, Swimming Pool, TV-Radio, Free inside parking, Barber and Beauty Shop, Two Cocktail Lounges, Two Restaurants, Newsstand, Gift Shop, Package Shop—Heart of Augusta—300 Rooms.
Towers: Single $14, double $16.

Downtowner Motor Inn: Reynolds at 8th St. (722-5361). **Single $9, double $12, twin beds $14.** 100% Air Conditioned, Radio-TV, Free parking. Swimming pool, Cocktail Lounge, Restaurant—100 rooms.

Warrick—Quality Motel: Broad at 4th St. (722-0212). **Single $10, double $14, twin beds $14.** Air Conditioned—TV, Free Parking, Free Continental Breakfast. Cocktail Lounge—69 Rooms.

University Motel: 1410 Gwinett St. (724-8204). **Single $7, double $9, 2 double beds $12.** Air Conditioned—TV, Free parking, Restaurant near-by, Adjacent Talmadge Memorial and University Hospitals—68 Rooms.

Medical Center Motel: 1480 Gwinett St. (722-4828). **Single $8, double $12, triple, $16.** Air Conditioned—TV, Free Parking, Restaurant next door, Adjacent Talmadge Memorial and University Hospitals—45 Rooms.

Howard Johnson Motor Lodge: 1238 Gordon Highway. (724-9613). **Single $10, double $12, twin beds $15.** Air Conditioned—TV, Swimming Pool, Free parking, Restaurant and Cocktail Lounge—61 Rooms.

Holiday Inn: 1602 Gordon Highway (798-2782). **Single $10, double $13, 2 double beds $15, $2 for extra person occupying room.** Air Conditioned—TV, Swimming Pool, Restaurant, Cocktail Lounge, Free Parking—110 Rooms.

Confirmation of your request for accommodations will be in accordance with preference indicated, if possible; if not, best substitutes will be made. Deposit of one day's room rent will be required with each request for accommodations.

Cut out and send to: Please Type or Print

HOUSING BUREAU, MEDICAL ASSOCIATION OF GEORGIA
Augusta Town House, Augusta, Georgia—Attn: Reservations Manager

Please reserve the following accommodations for the 1968 Annual Session of the Medical Association of Georgia.

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1st Choice ..... ☐ Double Room at $..... to $.....

2nd Choice ..... ☐ Double Room at $..... to $.....

3rd Choice ..... ☐ Twin Bedroom at $..... to $.....

☐ Other type .....

Arrival Date ..... Hour ..... A.M. ..... P.M.

Departure Date ..... Hour ..... A.M. ..... P.M.

THE NAME OF EACH HOTEL GUEST MUST BE LISTED. Include all names of all persons for whom you are requesting reservations and who will occupy the room(s):

Name of Occupant(s)	Address
.....	.....
.....	.....
.....	.....

Individual Requesting Reservations

Name .....

Address .....

City ..... State .....

Zip Code .....

If hotels or motels of your choice are unable to accept your reservations, the Housing Bureau will make reservations to fit your specifications elsewhere.

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NEW MEMBERS

Carrodeguas, Luis Active—Baldwin	Milledgeville State Hospital Milledgeville, Ga. 31062
Franco, Jaime Active—Laurens	Laurens Memorial Hospital Dublin, Georgia 31021
Fulmer, Thomas Earle Service—Fulton	V.A. Hospital Atlanta, Georgia 30329
Gregory, John E. Active—Muscogee	Medical Center Laboratory Columbus, Georgia
Guernica, Eduardo Active—Baldwin	Milledgeville State Hospital Milledgeville, Ga. 31062
Hallum, Alton Venson, Jr. DE-2—Fulton	80 Butler Street, S.E. Atlanta, Georgia 30303
Hartley, John H., Jr. DE-2—Fulton	5419 Caroline St. Houston, Texas 77004
Howard, William R. Active—Baldwin	Central State Hospital Milledgeville, Ga. 31061
Hurst, James B. Active—Bibb	Baldwin County Hospital Milledgeville, Ga. 31061
Joiner, James C., III Active—Bibb	626 First Street Macon, Georgia 31201
King, Delutha Harold Active—Fulton	985 Hunter St., N.W. Atlanta, Georgia 30314
Longino, Grady Estes Active—Laurens	V.A. Center Dublin, Georgia 31021
Maughon, Bob Robinson Active—Muscogee	1953 Seventh Avenue Columbus, Georgia
Morton, William J. DE-2—Fulton	80 Butler Street, S.E. Atlanta, Georgia 30303
Rieser, John Charles DE-2—Fulton	80 Butler Street, S.E. Atlanta, Georgia 30303
Trevejo, William A. Active—Ware	1921 Alice Street Waycross, Georgia
Turner, Harvey L., Jr. DE-2—Fulton	80 Butler Street, S.E. Atlanta, Georgia 30303
Wachsman, Harvey F. DE-2—Fulton	80 Butler Street, S.E. Atlanta, Georgia 30303
Wages, Tom L. Active—Chattahoochee	Park Street Buford, Georgia 30518
Watson, Francis M., Jr. DE-2—Fulton	80 Butler Street, S.E. Atlanta, Georgia 30303

SOCIETIES

Ralph G. Newton, Jr., has been installed as president of the **Bibb County Medical Society,** succeeding Sweeney Sikes. Joe Sam Robinson is the new president-elect; Waddell Barnes is vice president; Charlotte Neuberg is secretary-treasurer; and C. H. Richardson, Sr., is parliamentarian.

Harry E. Sims of Fort Valley is the new president-elect of the **Peach Belt Medical Society.** He will succeed outgoing president J. R. Arnall of Perry. F. B. Meserve of Warner Robins is secretary-treasurer.

Linton H. Bishop of Atlanta has been installed as president of the **Fulton County Medical Society** for 1968. J. Frank Walker is the president-elect. William C. Waters is vice president; Harrison Rogers is trustee and J. Norman Berry and William W. Moore, Jr., are vice councilors to the Medical Association of Georgia.

Stuart Prather, Augusta radiologist, has been installed as president of the **Richmond County Medical Society,** succeeding Daniel Sullivan. Ronald Galloway is the new president-elect. Walter Shepeard is vice president and Stephen Mulherin is secretary-treasurer.

John Zirkle, Savannah surgeon, has been named president-elect of the **Georgia Medical Society** and Thomas McGoldrick, internist, has been installed as president, succeeding Peter Scardino. Irving Victor is the new vice president and J. J. Doolan and Jeff J. Holloman have been re-elected treasurer and secretary, respectively.

Randall Winburn, Jr., and F. Debele Maner were named delegates to the Medical Association of Georgia, and Edward J. Whelan and J. C. Metts, Jr., were named alternate delegates.

The Eighth District will hold its Spring Meeting in conjunction with a medical seminar sponsored by the South Georgia Medical Society to be held in Valdosta on Saturday, April 6.

The speakers will be Dr. Lester Dragstedt from the University of Florida Medical School, Dr. Charley Smyth from University of Colorado Medical School and Dr. J. M. Montalov of the University of Mississippi Medical Center.

PERSONALS

First District

Governor Maddox has appointed **Louie H. Griffin** of Claxton as First District member of the State Board of Health to succeed **Julian Quattlebaum** of Savannah.

Peter Scardino of Savannah has an article entitled "Vertical Flap Ureteropevioplasty" in a recent medical volume, *Classical Articles in Urology*, published by Charles C Thomas Co. Dr. Scardino originally published the article in 1953 with the late **Charles L. Prince.**

An article in the *Savannah Morning News* featured **William Medart,** chief pathologist at the Memorial Medical Center, who has built a freeze drying machine for $250 which normally sells for $1500.

William Wilson Osborne has been elected president and chief of staff for the medical and dental staff of

Candler General Hospital in Savannah. **Julian Quattlebaum** was named vice president. Department chiefs for 1968 are Dr. Quattlebaum for surgery; **F. Debele Maner**, medicine; **W. G. Sutlive**, obstetrics and gynecology; **J. A. Hefferman, Jr.**, general practice; and **F. B. Bousquet, Jr.**, eye, ear, nose and throat. Also, **Richard Schley**, pediatrics; **Joseph McCormick**, pathology; and **David Robinson**, radiology.

Third District

A. B. Conger of Columbus addressed members of the PBX Club of Columbus at a dinner meeting December 19. He outlined the strides made in cancer research and treatment in the past 15 years.

Fourth District

William J. Briggs, II, of Marietta has been elected to active membership in the American Academy of General Practice.

Fifth District

John B. Griffin, Associate Professor of Child Psychiatry at Emory, who has been giving Saturday mornings to serving Newton County children, was officially introduced at the Mental Health Association's public meeting November 30 in Covington.

Thomas L. Tidmore, who is chief anesthesiologist at the Henrietta Egleston Hospital for Children in Atlanta, has been elected president of the Atlanta Association for Retarded Children, Inc. **W. C. Earle** is a member of the Board of Directors.

The new secretary-treasurer of the Georgia Industrial Medical Association is **H. K. Sessions** of Atlanta.

John T. Godwin participated in a recent meeting and workshop sponsored by the Southern Regional Education Board, American Association of Junior Colleges and National Health Council in Atlanta. The participants discussed "A Guide for Health Technology Program Planning" prepared for use by junior colleges in their participation in the training of Allied Health Personnel.

Atlanta ophthalmologist **Morgan Raiford** has been named "Boss of the Year" by the Atlanta Chapter of the National Secretaries Association.

John D. Thompson of Atlanta was elected Chairman of the Section on Obstetrics for 1968 by the Southern Medical Association at its annual meeting held in Miami in November. **F. Phinizy Calhoun, Jr.**, of Atlanta was named Chairman-Elect for the Section on Ophthalmology.

Robert M. Fine presented a paper at the Southern Medical Association meeting in Miami Beach entitled "Erythema Nodosum: A Form of Allergic Cutaneous Vasculitis." **Harold D. Meltzer** is the co-author. Dr. Fine also served on the panel of the Zola Cooper Histopathology Seminar.

Sidney Olansky and **H. Jordan Whyte** attended the annual meeting of the American Academy of Dermatology in December. Dr. Olansky conducted a roundtable discussion on venereal disease and appeared on a closed circuit television program on venereal disease. Dr. Whyte appeared on a television program regarding therapeutic challenges. Dr. Olansky also participated as a member of the Teaching and Scientific Committee of the Dermatology Foundation and attended the meeting of Professors of Dermatology.

Sixth District

James B. Craig, superintendent of Central State Hospital at Milledgeville, has been notified of his election as a Fellow of the American College of Psychiatrists.

The 1968 chief of staff and chairman of the executive committee of Macon Hospital is **Henry Tift. Calder Clay** was named chief of staff-elect and will serve automatically as secretary of the executive committee this year. Chosen to serve on the executive committee were **J. G. Etheridge, William O'Shaughnessey** and **W. D. Hazelhurst** on medical service and **Morris Brown** on surgical service.

The Middle Georgia Hospital medical staff officers for 1968 are **Charles R. Ireland**, president; **T. E. Rogers, Jr.**, vice president; and **Jack F. Menendez**, secretary. **C. H. Richardson, Sr.**, was awarded a 49-year service pin and ten year pins were awarded to **Dr. Rogers** and **H. H. Tift.**

Seventh District

Recently elected officers of the medical staff of John L. Hutcheson Memorial Tri-County Hospital for 1968 are **Warren Terrell**, Rossville, chief of staff; **John C. Ellis**, Rossville, vice chief of staff, and **Gordon L. Hixson** of Fort Oglethorpe, secretary. Other members of the executive committee of the medical staff are **E. G. Johnson**, chief of surgical services; **Roy Pope**, chief of general practice; **Fred Simonton**, chief of medical services; **Thomas H. Curtis**, chief of obstetrical and gynecological services; **Leroy Sherrill**, immediate past chief of staff; and **T. W. Alsobrook**, chairman of the credentials committee.

Robert Raitz has been elected president of the medical staff officers at Hamilton Memorial Hospital in Dalton. **R. T. Farrow** is vice president and **Neil D. Boggess, Jr.**, is secretary. Departmental chiefs of services are **A. M. Boozer**, medicine; **Paul L. Bradley**, surgery; **M. V. Dardin**, obstetrics and gynecology; **W. R. Tipton**, pediatrics; **Brooke Summerour**, anesthesiology; **Evelyn M. Stephenson**, pathology; and **Gunther Ehlers**, radiology. Clinic directors are **W. R. Tipton**, Heart Clinic, and **Murray B. Lumpkin**, Judd Memorial Tumor Clinic.

Floyd Morgan has been elected chief of staff at the Douglas County Memorial Hospital and **Claude V. VanSant, Jr.**, is the new vice chief of staff. **Clark Robinson** is secretary.

Eighth District

Key David McMurrain, Director of West Point Pepperell Medical Department, was elected president of the Georgia Industrial Medical Association at its recent meeting in Atlanta.

Ninth District

Harold G. Long of Dahlonega has been elected to active membership in the American Academy of General Practice.

J. Wade Knowlton has joined the staff of the Toccoa Clinic Medical Associates. He completed his residency in general surgery at Grady Memorial Hospital in Atlanta in July.

James H. Blair has also joined the Toccoa Clinic Medical Associates in the Department of Obstetrics and Gynecology. Dr. Blair was recently discharged from the U.S. Army where he was stationed at Martin Army Hospital at Fort Benning. Dr. Blair was also recently certified as a diplomate of the American Board of Obstetrics and Gynecology.

M. Clinton Doss will be practicing general medicine at the Toccoa Clinic Medical Associates. He joined the staff upon release from the U.S. Navy in January. He is a native of Carrollton and a graduate of the Medical College of Georgia.

Tenth District

George McInnes spoke to the Augusta Junior League on his experiences on medical service in Vietnam in early December.

Chief of Staff at Hart County Hospital in Hartwell is **Morriss Dalton. Randall E. Couch** is vice chief of staff and **J. Weldon Williams, Jr.,** is secretary.

Augusta orthopedist **Charles Freeman** is the new vice president of the Georgia Industrial Medical Association.

DEATHS

Frank E. Christopher, Sr.

Frank E. Christopher, Sr., 70, died December 7, 1967, in an Atlanta hospital. Dr. Christopher was on the staff of Georgia Baptist Hospital and Crawford W. Long Hospital.

A native of Ensley, Alabama, Dr. Christopher was a graduate of the University of Alabama and Emory University School of Medicine. He was a former medical director of the Atlanta Tuberculosis Association and was a member of the board of directors. Dr. Christopher was a member of the Fulton County Medical Society, the Medical Association of Georgia, and the American Medical Association.

Dr. Christopher was a member of Morningside Presbyterian Church. He is survived by his wife, the former Ola Kendall; a son, Frank E. Christopher, Jr., of Atlanta; two daughters, Mrs. Joan Quillen, Atlanta, and Mrs. Charles Tutt of Pensacola Beach, Florida; and a brother, Ralph Christopher of Fort Payne, Alabama.

Melvis Corbitt

Melvis O. Corbitt of Augusta died December 29, 1967, in Augusta. Dr. Corbitt was the wife of the late Marion L. Sumerau.

A native of Augusta, Dr. Corbitt was a graduate of the Medical College of Georgia and had practiced in Augusta for a number of years. She was a member of the Richmond County Medical Society, Medical Association of Georgia, American Medical Association and American Medical Women's Association. She was active in the Stroke Clinic.

Dr. Corbitt was a member of the Church of the Good Shepherd. She is survived by her son, C. F. Sumerau of Augusta, and one sister, Mrs. Allen Poss of Augusta.

John W. Daniel, Jr.

John W. Daniel, Jr., 63, of Savannah, died December 20, 1967, at the Memorial Medical Center in Savannah. He had been ill for a long time.

Dr. Daniel was a graduate of the University of Georgia and the Medical College of Georgia. He had practiced medicine in Savannah ever since finishing his medical studies. He was a member of the Georgia Medical Society and the Medical Association of Georgia.

Dr. Daniel is survived by his wife, Mrs. Elizabeth Lynah Daniel; two daughters, Mrs. John Pinholster of Savannah and Mrs. John Roberts of Miami, Florida; two step sons, Bronson C. Rumsey, Jr., of Denver, Colorado, and James Rumsey of Bryan, Texas; and two aunts, Mrs. Harold Tuthill of Savannah and Mrs. William McLeod.

Jesse Edwin Davis

Jesse Edwin Davis, 82, an Atlanta physician for more than 50 years, died December 19, 1967, in a private hospital.

Dr. Davis was a native of Atlanta and a graduate of the old Atlanta Medical School. He practiced until about five years ago.

Dr. Davis was a member of the American Medical Association and held life memberships in the Fulton County Medical Society and the Medical Association of Georgia. He received an outstanding service award from the Medical College of Georgia. He was also a member of Palestine Lodge No. 486, F & AM.

Survivors include his wife, the former Eufa Swilling; two sons, Jesse E. Davis, Jr., Columbia, South Carolina, and Marion T. Davis of Atlanta; and one brother, William Davis of Atlanta.

Wright Grant Hicks

Wright Grant Hicks, 46, of Jackson, died November 12, 1967, at his home in Jackson following a long illness.

Dr. Hicks was a graduate of the University of Georgia and the Medical College of Georgia. He interned at the University Hospital in Augusta and served in the U.S. Army Medical Corps until 1948 when he established his practice in Jackson. He completed a year of residence surgery at the Macon Hospital in 1962.

Dr. Hicks was the first Chief of Staff of the Sylvan Grove Hospital which opened in 1962. He was a member of the American Medical Association, the Medical Association of Georgia and the Spalding County Medical Society. He was a director of the Georgia Academy of General Practice and of the Butts County Medical Society.

Dr. Hicks was also the first president of the Butts County Athletic Association and former chairman of the Butts County Bulldog Club and of the University of Georgia Alumni Society. He was a former member of the Jackson Kiwanis Club.

Dr. Hicks is survived by his wife, Mrs. Margaret Pierce Hicks; three sons, Wright G. Hicks, Jr., Bruce Hicks and Joseph Hicks, all of Jackson; and one brother, Dr. David Hicks of Orlando.

Miles Warren Williams, Sr.

Miles Warren Williams, Sr., 57, of Camilla, died December 29, 1967, at his home.

Dr. Williams was a native of Jacksonville, Florida, and a graduate of the Emory University School of Medicine. He interned in Savannah and Baltimore and moved to Camilla in 1936. He interrupted his practice

during World War II to serve five years in the United States Army.

Dr. Williams was a senior partner in the Camilla Clinic. He was a member of the Mitchell County Medical Society and the Medical Association of Georgia. A former president of the Camilla Chamber of Commerce, Dr. Williams was a member of the Camilla Rotary Club and a member of the Camilla Methodist Church.

Survivors include his wife, Hattie Greenway Williams; two sons, M. W. Williams, Jr., of Macon, and Jim G. Williams of Athens; a brother, Dr. Conrad Williams of Valdosta; two sisters, Mrs. Julian Rivers of Charlotte, North Carolina, and Miss Elizabeth Williams of Camilla, and two grandchildren.

BIBB COUNTY MEDICAL SOCIETY SURVEYS DOCTORS' ACTIVITIES

The results of a survey conducted last year by Z. Sweeney Sikes, Jr., president of the Bibb County Medical Society, show that the 187 members of the Society donate approximately 8,326 hours a year to organizations and activities separate from their practices.

One hundred and fifty-five active positions in fifty-six organizations are filled by members of the Bibb County Society.

Some of these community organizations include the American and Bibb County Red Cross Associations, the Bibb County TB Association, the Macon Tumor Clinic, the Macon Rescue Mission, the Bibb County and American Cancer Societies, the Boy Scouts, the Junior Deputy League, the Middle Georgia Camellia Society, and the Boys Club of Macon. One Macon doctor was owner of a professional baseball team.

Middle Georgia doctors in 1966 contributed some 1,436 hours and treated some 43,626 patients at the Macon Hospital outpatient charity clinic. The doctors regularly visit the clinic, seeing patients and teaching interns and residents.

Seventy-five doctors in the Bibb County Medical Society are certified by specialty boards in their fields of medicine.

Middle Georgia doctors are members in 97 state, regional, national and international specialty medical organizations. Meetings of these societies are regularly attended and the majority of the doctors attend at least one or two meetings annually.

In addition to being members of these specialty organizations, Macon and Middle Georgia doctors have authored approximately 89 original medical papers that have been published in medical journals.

The Bibb County Medical Society each year donates trophies to Macon high schools to be awarded in their physical fitness programs. Last year the Society donated 87 trophies. Also as an annual project the Society contributes first aid kits to all the local youth baseball teams as well as contributions to Little League teams in the Macon area.

Middle Georgia physicians regularly give talks to church and social organizations on subjects dealing with their specialty in medicine.

In 1964, some 100 physicians donated approximately 1,000 hours to the Stop Polio Campaign. Doctors filled both the chairmanship and co-chairmanship positions of the Stop Polio Campaign Committee.

In 1966, Society members contributed an afternoon in their office for the free examination of female patients in the Bibb County Cancer Society's Breast Cancer Detection Campaign.

At least 25 physicians are active in supporting the political candidates of their choice with time and money and one member of the Society is mayor of Gordon.

Each of the 187 members of the Bibb Medical Society contributes approximately $600-$3,500 annually to churches and charities.

Fourteen doctors serve as deacons in their churches, seventeen on official boards of their churches, one on the educational committee, seven as Sunday School teachers and three are lay leaders in the Episcopal Church.

Officers of the Bibb County Medical Society include Dr. Sikes, president; Dr. Ralph G. Newton, Jr., president elect; Dr. Joe S. Robinson, vice president; Dr. Charlotte Neuberg, secretary-treasurer; and Dr. Charles H. Richardson, Sr., parliamentarian.

CONGRESS TO MEET IN CHICAGO ON SOCIO-ECONOMICS OF HEALTH CARE

The Second National Congress on the Socio-Economics of Health Care will be held in Chicago on March 22 and 23, 1968, at the Palmer House. Dr. John T. Mauldin, MAG President, and Mr. Edwin Smith, Executive Secretary, will represent the Medical Association of Georgia at the Congress.

The Congress is sponsored by the Council on Medical Service and the Division of Socio-Economic Activities of the American Medical Association. More than twenty-five speakers will take part in the program delivering addresses and participating in panel discussions. Milford O. Rouse, M.D., President of the American Medical Association and Charles L. Hudson, M.D., Immediate Past President, are among the speakers.

1968 CALENDAR OF MEETINGS

State

February 22-23—Internal Medicine: Recent Advances in Therapy, Continuing Education Course, Medical College of Georgia, Augusta, Ga.

February 23-24—American College of Physicians, Alabama Regional, Point Clear, Ala.

March 4-7—New Orleans Graduate Medical Assembly, New Orleans, La.

March 12-13—Basic Electrocardiography for the Practitioner, Continuing Education Course, Medical College of Georgia, Augusta, Ga.

March 19-20—Recent Developments and Clinical Applications in Obstetrics and Gynecology, Continuing Education Course, Medical College of Georgia, Augusta, Ga.

April 14-17—Atlanta Graduate Medical Assembly, Marriott Motor Hotel, Atlanta, Ga.

May 5-7, 1968—114th Annual Session of the Medical Association of Georgia, Town House, Augusta.

Regional

March 7-9—Southern Society of Anesthesiologists, Sheraton-Dallas Hotel, Dallas, Tex.

March 25-28—Southeastern Surgical Congress, Sheraton-Park Hotel, Washington, D.C.

National

February 19-21—American College of Surgeons, Sectional Meeting, Statler Hilton, Dallas, Tex.

February 28-March 3—American College of Cardiology, San Francisco Hilton Hotel, San Francisco.

March 1-3—American Association of Pathologists and Bacteriologists, The Drake Hotel, Chicago, Ill.

March 3-7—International Academy of Pathology, Drake Hotel, Chicago, Ill.

March 9-10—American Psychiatric Association Colloquium on Postgraduate Teaching of Psychiatry, Roosevelt Hotel, New Orleans, La.

March 11-13—American College of Surgeons (Sectional Meeting for Doctors and Nurses), Williamsburg Inn, Williamsburg, Va.

March 15-16—AMA Council on Mental Health Conference of State Mental Health Representatives, Drake Hotel, Chicago, Ill.

March 15-20—International Congress of Lymphology, Fontainebleau Hotel, Miami Beach, Fla.

March 16—Advances in Gynecological Endocrinology, Vanderbilt University, Nashville, Tenn.

March 18-20—American Academy of Pediatrics, Regency-Hyatt House, Atlanta, Ga.

March 22-23—National Congress on the Socio-Economics of Health Care, Palmer House, Chicago, Ill.

March 24-30—American Society of Clinical Pathologists (Interim), Roosevelt Hotel, New Orleans, La.

March 30-April 3—American Society of Abdominal Surgeons, Sherman House, Chicago, Ill.

April 4-6—National Conference on Health Education of the Public, Pick Congress Hotel, Chicago, Ill.

April 5-6—Committee on Disaster Medical Care Regional Conference on Disaster Medical Care, Statler Hilton Inn, Durham, N.C.

April 7-11—American Radium Society, Fontainebleau Hotel, Miami Beach, Fla.

April 9-12—American Association of Anatomists, Jung Hotel, New Orleans, La.

April 10-12—Plastic Surgery Research Council, University of North Carolina, Chapel Hill, N.C.

April 16-17—American Association of Planned Parenthood Physicians, Gunter Hotel, San Antonio, Tex.

April 21-22—American Broncho-Esophagological Association, Hollywood Beach Hotel, Hollywood Beach, Fla.

April 21-26—American Laryngological, Rhinological and Otological Society, Hollywood Beach Hotel, Hollywood Beach, Fla.

April 22-25—American Orthopaedic Association, Boca Raton Club, Boca Raton, Fla.

April 25—American Society for Head and Neck Surgery, Hollywood Beach Hotel, Hollywood, Fla.

April 25-26—American Geriatrics Society, Roosevelt Hotel, New Orleans, La.

April 27-May 1—American Academy of Facial Plastic and Reconstructive Surgery, Diplomat Hotel, Hollywood Beach, Fla.

April 28-May 1—American Association of Plastic Surgeons, Shamrock-Hilton Hotel, Houston, Tex.

June 16-20—American Medical Association Annual Meeting, San Francisco, Calif.

GEORGIA HIGHWAY SLAUGHTER

Yearly Totals

1967	1,583 Killed
1966	1,605 Killed
1965	1,354 Killed
1964	1,314 Killed
1963	1,278 Killed
1962	1,106 Killed
1961	1,017 Killed

Through December 1967
1,583 KILLED

Same Period 1966
1,583 KILLED

December 1967
110 KILLED

Economic Loss

1967	$284,940,000
1966	288,900,000
1965	243,720,000
1964	236,520,000
1963	230,040,000
1962	199,080,000
1961	162,720,000

What's Happening?

At first glance it would appear that Georgia's 1967 traffic fatalities were held on an even keel with 1966, and this could turn out to be true. As of New Year's Day, fatalities through December 31 were 1,583. At this same time last year, 1966 fatalities totaled 1,583. However, as the weeks and months went by in 1967, people who had been badly injured in 1966 collisions died, and the total soared to 1,605. We have no idea how many deaths will result in 1968 from injuries sustained in 1967 collisions. Only time will tell the grim story.

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HIGHLIGHTS OF THE MAG EXECUTIVE COMMITTEE OF COUNCIL MEETING, JANUARY 7, 1968–ATLANTA

This summary is being published so that the MAG membership may be advised in brief of the actions of the Association's Council and Executive Committee. It covers only major actions and is not intended as a detailed report. Full minutes of these meetings are available upon any member's request to the MAG Headquarters Office.

MAG Contract With the State Department of Public Health wherein the MAG will provide consultative services for the Medical Assistance Recipients Program (MEDICAID) was reviewed by the Executive Committee and it was pointed out that the Health Department wished to continue this arrangement. The Executive Committee concluded that the contractual arrangement should be renewed after review by the MAG Attorney.

A Legislative Review was given to the Executive Committee by Legislative Committee Chairman J. Frank Walker, M.D., along with Committee member Harrison Rogers, M.D., and Staff man Jim Moffett. This included two new matters: one dealing with licensure of foreign physicians and one with the membership on the State Board of Health.

In the first, a bill which would have repealed the provision which prohibits the issuing of a license to practice to non-citizens of the United States will be amended so as to require that an applicant who is not a citizen must have filed with the Office of Immigration a Declaration of Intent to become a citizen.

In the second instance, it was learned that the Georgia Hospital Association was seeking legislation to allow for the appointment of a Hospital Administrator to the State Board of Health. The Executive Committee went on record as favoring no increase in the Board as it is presently constituted.

The Executive Committee also gave its backing to the Legislative Committee in its support of legislation for a bill to amend the code with relation to legal therapeutic abortion, and their support of a bill giving the Department of Education the authority to require measles vaccine before entering public or private schools.

Component County Medical Society apportionment of Delegates to the MAG Annual Session came under scrutiny since it was discovered that one county society has lost sufficient members in 1967 to cause a reduction of one delegate from their delegation. This matter was referred to the Constitution and Bylaws Committee with the consensus of the Executive Committee that the county societies should be given sufficient time in January to elect their delegates after the MAG headquarters staff has notified them of the number to which they are entitled.

At the same time it was pointed out that the Constitution and Bylaws Committee should consider the fact that the Bylaws seem to require a county society to have at least five members, and that there are now six societies which do not meet that requirement.

The Student AMA Chapter at Emory will host a caucus of SAMA delegates from the eleven Chapters in

the Southeastern States. Their request for financial assistance for this purpose was considered and approved by the Executive Committtee.

Other Matters Considered included the following:

Louie H. Griffin, M.D., of Claxton was recognized as having been appointed by the Governor as First District Representative on the State Board of Health.

William S. Hagler, M.D., of Atlanta was appointed to the Interprofessional Council. **Virgil Williams, M.D.,** of Griffin was appointed Alternate.

Fred L. Allman, M.D., of Atlanta was appointed to the Georgia Committee on Youth Smoking and Health, and their planned conference was endorsed.

AMA Conference on Health Care of the Poor was reported on by Dr. Emory Bohler who attended as MAG's representative. This meeting was subjected to demonstrations by pressure groups and has instituted an evaluation of the effectiveness of such meetings.

The Next Meeting of the Executive Committee was scheduled for February 4, 1968, at the Riviera Motor Hotel immediately after adjournment of the Officers' Conference.

PUBLIC HEALTH SURVEY TO VISIT ATLANTA AREA

The Public Health Service's Health Examination Survey, authorized by Congress in 1956, will visit the Atlanta area this month to examine a sample of the teenaged population (ages 12 through 17 years). The Survey will be conducted during the period February 9 through March 21, 1968. This will be a part of a series of examinations of a nationwide health survey of some 8,000 youngsters.

About 200 youths to be examined will be chosen by a scientific sampling process from the 12-through-17-year population of Cobb, DeKalb, and Fulton Counties.

Purpose of the examinations is to collect on a uniform basis statistical information on various aspects of the health of the youngsters and to obtain data on certain physical and physiological measurements relating to growth and development in this age group.

The process will include a special examination by a physician of the eyes, ears, nose and throat, heart and neuromuscular systems; a dental examination by a dentist; a test of visual acuity and color vision; recordings of blood pressure; biological and biochemical tests of a blood sample, an audiometric test for hearing performed in a soundproofed room; an X-ray of the chest for cardiovascular and pulmonary abnormalities; a 10-lead electrocardiogram and phonocardiogram of the heart; a timed vital capacity test using a wedge spirometer; an exercise tolerance test under a measured workload using a treadmill; a gripstrength test; recordings of height, weight, and various other measurements of growth and development; and measurements of verbal, perceptual, and social skills by a psychologist. This health examination of youths is referred to as the Third Cycle of the Health Examination Survey. Earlier, a Second Cycle of the children's health examinations (ages 6 through 11 years) was completed in December 1965. Over a 30-month period, 7,129 children were examined in 40 locations across the nation. A First Cycle of adult health examinations, ending in late 1962, completed a three-year survey and examined a total of 6,672 adults (ages 18 through 79 years).

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DELTA'S JETS FLY STRETCHER PASSENGERS

Incapacited travelers, who otherwise would be subjected to long, tedious trips via ground transportation, can now jet between certain cities on Delta Airlines' route system in a matter of hours. The passengers can fly on specially equipped standard DC-8's on stretchers provided by the airline, mounted in the forward (first class) cabin lounge area of the airplanes. Draw curtains provide complete privacy in the stretcher area.

Prospective stretcher passengers would, prior to their flight:

(1) Provide a medical certificate from a licensed authority;
(2) Be accompanied by one or two attendants who would care for the passenger during the trip and who would occupy the adjoining seats;
(3) Be responsible for the loading and unloading arrangements, cost of ambulance service, hospitalization expenses or other ground expenses.

The one way charge for the carriage of the stretcher passenger, including not more than two attendants, is four first class jet fares, applicable between the cities where the stretcher passenger is carried. The usual free baggage allowance will apply to each fare paid. Arrangements can be made through local Delta Reservation offices for the handling of stretcher passengers.

INDUSTRIAL MEDICAL ASSOCIATION MEETS MARCH 23

The Industrial Medical Association will meet March 23, 1968, at Callaway Gardens. Two speakers highlight the meeting.

The morning session, to run from 9 a.m. until noon, will feature Dr. Donald J. Birmingham, Professor of Dermatology and Syphilology at Wayne State University School of Medicine. He will speak on "Diagnosis, Treatment and Prevention of Industrial Dermatitis."

The afternoon session will begin at 1 p.m. and adjourn at 4 p.m. Dr. Norman J. Roberts, Associate Professor of Preventive Medicine at the University of Pennsylvania School of Medicine, will speak on "Contemporary Principles and Techniques in Health Examinations."

The registration fee of $10.00 is payable at time of registration or may be mailed in advance to Dr. Key D. McMurrain at the West Point Pepperell Manufacturing Company, West Point, Georgia.

CONGRESS OF CARDIOLOGY MEETS IN PERU IN APRIL

The Eighth Interamerican Congress of Cardiology will take place in Lima, Peru, on April 21-27, 1968. The Congress, sponsored by the Interamerican Society of Cardiology, will represent the interests of the Latin American nations, Canada, and the United States.

Plans for travel and tours for American Heart Association members and their families are being developed by SITA World Travel. Questions regarding travel arrangements should be directed to SITA at 50 Rockefeller Plaza, New York, New York.

PEDIATRICIANS JOIN WITH O.E.O. AS MEDICAL CONSULTANTS TO HEAD START

The American Academy of Pediatrics has signed a contract with the U.S. Office of Economic Opportunity to organize and direct the Medical Consultation Program of Head Start child development programs in nearly 2,000 communities in this country. The AAP will insure that health services provided through Head Start adequately meet the health needs of the children and their communities.

Robert S. Mendelsohn, M.D., F.A.A.P., a Chicago pediatrician, will direct the program.

Sargent Shriver, director of O.E.O., said that this contract represents a new type of relationship between an agency of the Federal Government and a voluntary professional organization.

The AAP will begin by selecting about 300 physician consultants from its membership and other leaders in the child health field to evaluate the medical aspects of Head Start programs at the state and local levels. The consultants will work with the medical director and other health professionals in Head Start projects. They will review medical aspects of Head Start applications, help plan medical programs, and work with O.E.O. representatives responsible for funding and evaluating Head Start health programs.

William S. Anderson, M.D., president of the American Academy of Pediatrics, said that the Academy Executive Board and staff are "enthusiastic about the opportunity this program offers for developing responsible pediatric leadership in an important area of child health programming. I believe this is an activity which will most certainly expand," he said, "and could set a significant trend in the programs of medical organizations."

EASTER SEAL CAMPAIGN WILL BEGIN MARCH 1

The 1968 Easter Seal Campaign will begin March 1 and continue until April 14, Easter Sunday, it was announced by Sumner G. Whittier, executive director, National Society for Crippled Children and Adults.

During those weeks, a widespread appeal for funds will be made by hundreds of state and local Easter Seal affiliates to finance treatment and rehabilitation for crippled children and adults in 50 states, Puerto Rico and the District of Columbia.

Last year, nearly a quarter million handicapped persons received help from Easter Seal societies, Mr. Whittier said. But needs of the handicapped and costs of providing expert professional care are rising, and more money than ever before will be needed to serve the handicapped during 1968.

The Society's primary source of income is from the annual campaign, during which appeals for contributions are made to the public through the distribution of Easter Seals and other special promotions.

Funds contributed will support some 2,000 facilities and programs of Easter Seal societies around the nation, including treatment centers, rehabilitation centers, sheltered workshops, recreation centers, summer camps and many others.

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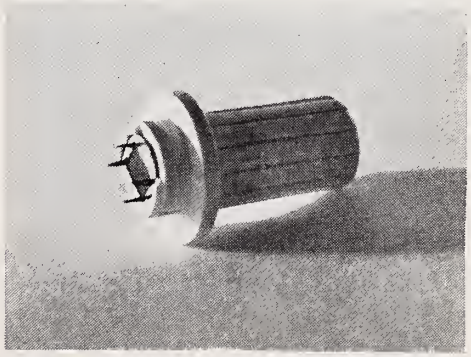

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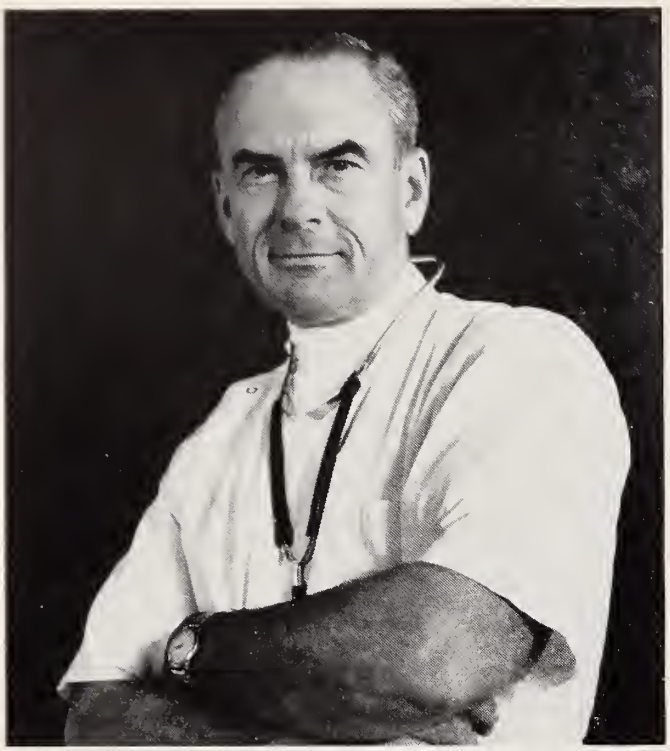

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THE MONTH IN WASHINGTON

President Johnson signed into law the social security legislation which included changes in medicare and medicaid advocated by the medical profession.

It provides for a record high minimum 13 per cent increase in cash benefits for 24 million Americans, starting in March. Beginning April 1, one dollar a month of the increase will be withheld from the checks of those participating in voluntary Plan B of medicare which covers part of physician fees and other medical services other than hospitalization.

The total premium for Plan B insurance is now $6 a month, half of which is paid by the federal government. Beginning April 1, the premium will be increased to $8, with the government paying $4 and the participant $4.

According to HEW, about 20 cents of the $1 increase was needed to cover costs which were originally underestimated. Another 25 cents would cover expected increase of use under the program. An anticipated 5 per cent increase in physician fees would account for another 25 cents, HEW said.

The social security taxable base also was increased, effective January 1, from $6,600 to $7,800. The tax rate for this year will remain the same as under the old law, 4.4 per cent on both the employee and employer and 6.4 per cent on self employed. Tax rate increases are set for subsequent years through 1987.

Charges in medicare and medicaid include:

Medicare

—Payment of physician fees is authorized either to the patient on the basis of an itemized bill, either unpaid or receipted as paid, or to the physician under the assignment method.

—Payment is authorized for full reasonable charges for radiological or services furnished by physicians to hospital inpatients.

—Hospital outpatient diagnostic services are transferred from the hospital insurance program (Plan A) to the supplementary medical insurance program (Plan B). The change was designed to simplify the procedure for paying benefits for hospital outpatients.

—The requirement of physician certification of the medical necessity for admission to general hospitals and for hospital outpatient services was eliminated.

—Medicare beneficiaries are given a lifetime reserve of 60 additional days of hospital care after the 90 days covered in a spell of illness. The beneficiary must pay the first $20 per day for the additional hospitalization.

—The Secretary of HEW was directed to study and report to Congress by January 1, 1969, the effects of covering drugs under medicare and of establishing quality and cost standards for drugs provided under social security health programs.

—Services of podiatrists are authorized under medicare to the extent that a state's law permits, but routine foot care is not covered.

—Outpatient services furnished by physical therapists are authorized within certain limitations.

—The Secretary of HEW was directed to study and make recommendations of adding services of chiropractic and optometrists to Plan B.

—Payment is authorized under Plan B for diagnostic x-rays taken in a patient's home or a nursing home.

Medicaid

—States are limited in setting eligibility income levels for federal matching purposes.

—States are given until January 1, 1970, to buy-in medicare Plan B insurance for aged medicaid beneficiaries.

—States are authorized to make direct payments to medicaid beneficiaries for physicians' and dentists' services if the beneficiary is not receiving cash assistance.

—States are permitted to select either the five basic health services, or seven out of the 14 authorized, for the medically indigent. The basic five must be provided for those receiving welfare cash benefits. The basic five are: inpatient hospital services, outpatient hospital services, other laboratory and x-ray services, skilled nursing home services and physicians' services.

—States must license administrators of nursing homes and set minimum nursing home standards if these institutions are to be eligible to participate in the medicaid program.

—States must establish methods and procedures to safeguard against unnecessary utilization of health care services and to assure that payments for such services and drugs do not exceed reasonable charges.

Under the program for Aid to Families with Dependent Children (AFDC), states now must offer birth control services to appropriate beneficiaries with acceptance on a voluntary basis. Authorizations for federal financial aid for maternal and child health programs are increased. Services of optometrists are added to child health programs.

* * *

Dr. James L. Goddard, commissioner of the Food and Drug Administration, estimated that about 300 drugs, marketed under 1,600 brand names, will be forced off the market because of ineffectiveness for treatment of medical conditions.

An evaluation of some 3,000 drugs placed on the market from 1938 to 1962 was started in June, 1966. It is being conducted by 29 panels of 200 medical and pharmaceutical specialists under the direction of the National Academy of Sciences-National Research Council. With the first panel reporting in January, the last report is due in mid-1969.

* * *

The federal government has licensed a live, attenuated mumps virus vaccine especially recommended for adolescent and male adults who can become sterile from the relatively innocuous childhood disease.

The vaccine, developed over a five-year period by the Merck, Sharp and Dohme Research Laboratories, was not recommended for routine use in infants and young children pending development of more information in the duration of the immunity it provides.

Dr. William H. Stewart, U.S. Surgeon General, said excellent protection against naturally occurring mumps has been observed for the first year after the single-infection live vaccine.

From the Washington Office
American Medical Association
January 5, 1968

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Indications: Osteoarthritis, rheumatoid arthritis, rheumatoid spondylitis, psoriatic arthritis, gout, painful shoulder (peritendinitis, capsulitis, bursitis and acute arthritis of that joint), acute superficial thrombophlebitis, severe forms of a variety of local inflammatory conditions. (In inflammatory conditions not involving prolonged or fatal disease, use only when severity of condition balances potential toxicity.)
The drug has no significant uricosuric action but is of value only in the treatment of acute gouty arthritis.
Contraindications: Edema; danger of cardiac decompensation; history or symptoms of peptic ulcer; renal, hepatic or cardiac damage; history of drug allergy; history of blood dyscrasia. The drug should not be given when the patient is senile or when other potent drugs are given concurrently.
Warning: Tandearil is an analog of phenylbutazone; sensitive patients may be cross-reactive. If coumarin-type anticoagulants are given simultaneously, watch for excessive increase in prothrombin time. Instances of severe bleeding have occurred. Pyrazole compounds may potentiate the pharmacologic action of sulfonylurea, sulfonamide-type agents and insulin. Carefully observe patients receiving such therapy. Use with great caution in the first trimester of pregnancy.
Precautions: Before prescribing, carefully select patients, avoiding those responsive to routine measures as well as contraindicated patients. Obtain a detailed history and a complete physical and laboratory examination, including a blood count. The patient should not exceed recommended dosage, should be closely supervised and should be warned to discontinue the drug and report immediately if fever, sore throat, or mouth lesions (symptoms of blood dyscrasia); sudden weight gain (water retention); skin reactions; black or tarry stools or other evidence of intestinal hemorrhage occur. Make regular blood counts. Discontinue the drug immediately and institute countermeasures if the white count changes significantly, granulocytes decrease, or immature forms appear. Use greater care in the elderly and in hypertensives.
Adverse Reactions: The most common are nausea, edema and drug rash. Swelling of the ankles or face may be minimized by with-

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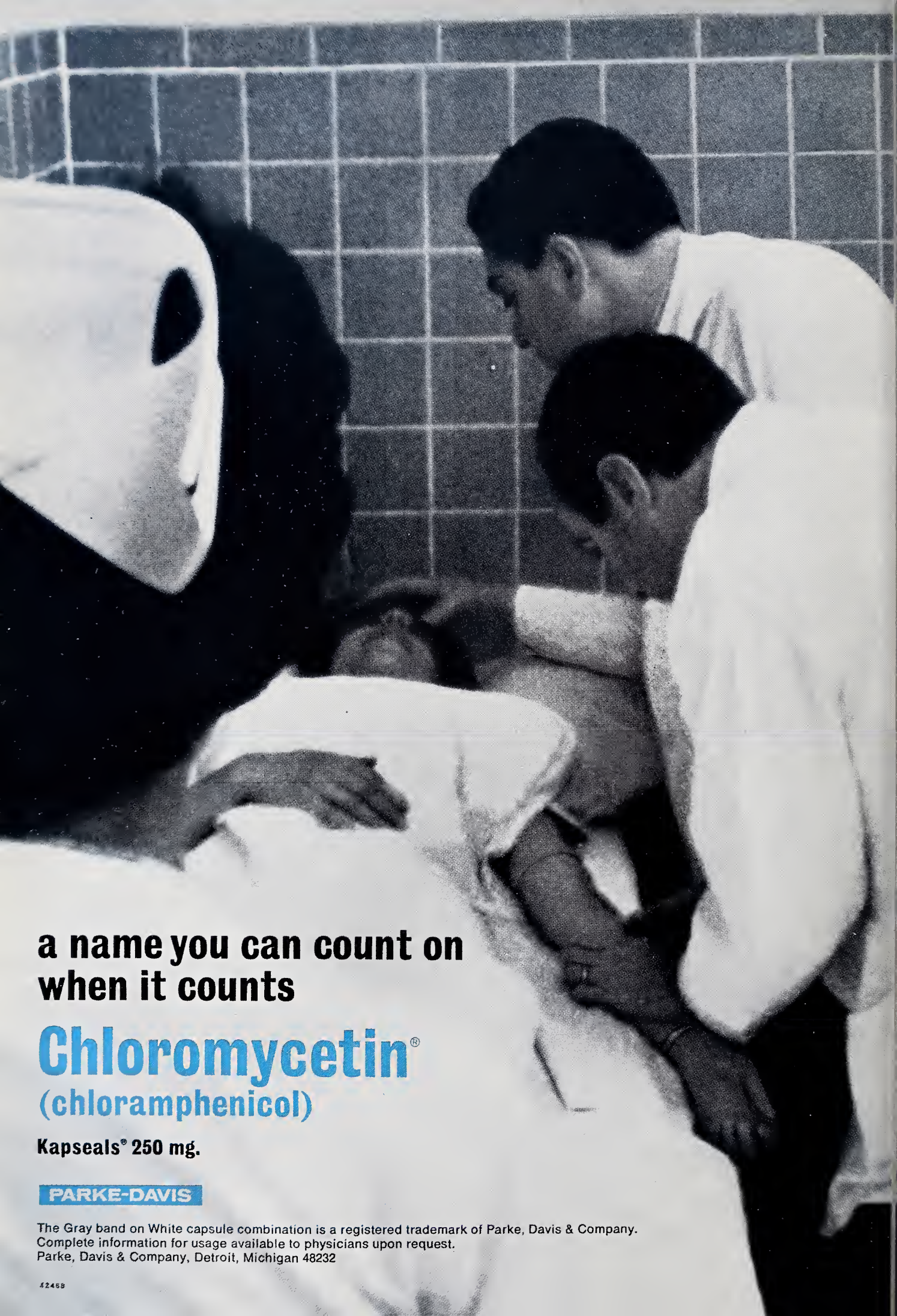
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MARCH 1968 *Volume 57, Number 3*

JOURNAL OF THE MEDICAL ASSOCIATION Georgia

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JOURNAL OF THE MEDICAL ASSOCIATION Georgia

114th Annual Session Official Call

Extended to All Officers and Members of the Medical Association of Georgia

THE OFFICIAL CALL for the 114th Annual Session of the Medical Association of Georgia is hereby extended to all Association members. This two and one-half day meeting will be convened May 5, 6, and 7 at the Augusta Town House Motor Hotel, Augusta, Georgia. The Association will conduct scientific sessions and general business meetings, and the House of Delegates will be convened for their annual meeting. Scientific and Commercial exhibits will be on display in the Augusta Town House adjacent to the main meeting rooms. Social events for the membership have been planned and many of the Specialty Societies will have their own luncheon and dinner meetings. The Woman's Auxiliary to the Medical Association of Georgia will hold their 43rd Annual Convention in conjunction with the Association Annual Session at the Augusta Town House.

Registration

The MAG Official Registration Desk will be located on the second floor of the Augusta Town House adjacent to the French Room. The French Room, Spanish Room and Italian Room will serve to house the MAG Scientific and Commercial Exhibits and will be used as the entrance and exit to the Embassy Room which is the main meeting room for the session. Other meetings will convene in the Georgian, Walton, Oak, Fenwick, Telfair, Boxwood and Teakwood Rooms which are also on the second floor of the Augusta Town House.

The Registration Desk will be open for registration of MAG members and their guests on Sunday, May 5, from 1:00 p.m. to 6:00 p.m.; Monday, May 6, from 8:00 a.m. to 5:00 p.m. and Tuesday, May 7, from 8:00 a.m. to 12:00 noon.

MAG members and guests are requested to register at the MAG Registration Desk *immediately on arrival* at the Augusta Town House to obtain badges and programs. No one will be admitted to the Exhibit Hall, Meeting Rooms or other MAG functions without MAG Official registration badges.

MAG Scientific Sessions

MAG Scientific Section and Joint Section Meetings will convene Sunday afternoon, May 5, from 2:00 p.m. to 5:00 p.m.; Monday morning, May 6, from 10:30 a.m. to 12:00 noon and Monday afternoon, May 6, from 2:30 p.m. to 5:00 p.m.

MAG General Business Sessions Embassy Room

The Association will convene its first General Business Session for all MAG members on Sunday afternoon, May 5, at 5:00 p.m. at which time nominations for MAG Offices will be made. The second General Business Session will be held jointly with the MAG House of Delegates meeting on Monday morning, May 6, at 9:00 a.m. to 10:30 a.m. During this business session the MAG President-Elect will outline his program for 1968-69. The third and final General Business Session will convene jointly with the MAG House of Delegates final meeting on Tuesday morning at 9:00 a.m. to 12:00 noon. At this last business session, MAG awards will be presented, election results announced and new officers installed—and the entire 114th Annual Session will be adjourned.

MAG House of Delegates Sessions Embassy Room

The first session of the MAG House of Delegates will meet Monday morning, May 6, at 9:00 a.m. to 10:30 a.m. At this session all reports and resolutions will be introduced to the House for referral to House Reference Committees.

All Reference Committees of the House will meet concurrently on Monday afternoon, May 6, in the Boxwood A, Boxwood B, Oak, Walton and Fenwick Rooms from 2:30 p.m. to approximately 5:00 p.m. Delegates and all MAG members are urged to attend these Reference Committee meetings so that they may make their views known to assist these Committees in their deliberations on those items of business before the Association House of Delegates. The second and final session of the MAG House of Delegates will convene Tuesday morning, May 7, at 9:00 a.m. to 12:00 noon. At this session, the House Reference Committees will report their recommendations and the House will vote on these items of business which set MAG policy for 1968-69.

Both sessions of the House will be held jointly with the MAG General Business sessions to facilitate the overall business of the Association.

Delegates are urged to attend both sessions of the House to fulfill their responsibility to the County Medical Society which they represent. *All Delegates are requested to attend both sessions of the House at least 15 minutes prior to the time they are convened so that Delegates may be registered without delay of the meetings.* Registration of MAG Delegates will be conducted at a SPECIAL DELEGATES REGISTRATION DESK just inside the Embassy Room 30 minutes preceding the convening of both sessions of the House so that attendance and voting privileges may be checked by the House Credentials Committee. *During this Delegates Registration, Special Badges will be given Delegates.* As both sessions of the House will be held jointly with MAG General Business Sessions, *special seating areas will be reserved for Delegates* and their Special Badges will admit them to this separate section of the meeting room.

MAG Message Center

A Message Center will be maintained at the MAG Official Registration Desk for the convenience of the membership. Pages from the Woman's Auxiliary to MAG will staff this center during the entire session for incoming messages only.

An Official Bulletin Board at this message center will be available for notices of special importance during the Annual Session.

MAG Headquarters Office and Press Room

The Association Headquarters Office Staff will maintain a Headquarters Office in Room 202 on the second floor of the Augusta Town House for the purpose of staff secretarial activities in conjunction with the conduct of Association business during the meeting.

An MAG Press Room will also be available for newspaper, radio and TV personnel during the entire meeting. This room will be adjacent to the MAG Registration Desk on the second floor of the Augusta Town House.

MAG Memorial Service

The Medical Association of Georgia will hold its traditional annual Memorial Service at the first Joint General Business and House of Delegates Session on Monday morning, May 6, at 9:00 a.m. in the Embassy Room. All members and their guests are invited to attend this service which is held in memory of those members who have died during the past Association year. The event will honor and recall the service and contributions of the following medical practitioners:

Clara Barrett, Atlanta, February 1, 1968
Gregory Bateman, Atlanta, February 28, 1968
W. W. Battey, Augusta, January 12, 1968
Richard A. Billings, Atlanta, February 6, 1968
Robert T. Carney, East Point, July 17, 1967
F. E. Christopher, Atlanta, December 7, 1967
T. H. Clark, Douglas, October 18, 1967
C. A. Clements, Trion, July 31, 1967
Melvis O. Corbitt, Augusta, December 29, 1967
Frank M. Cronic, Macon, January 19, 1968
John W. Daniel, Jr., Savannah, December 20, 1967
J. E. Davis, Atlanta, December 19, 1967
Tudor C. Davis, Atlanta, July 28, 1967
W. B. DuVall, Atlanta, July 27, 1967
C. W. Dyer, Macon, February 15, 1968
G. H. Faggart, Savannah, August 18, 1967
R. W. Fowler, Sr., Marietta, October 28, 1967
Odis G. Glover, East Point, August 9, 1967
E. N. Gleaton, Savannah, January 17, 1968
Richard C. Hackney, Atlanta, February 7, 1968
E. C. Herman, LaGrange, September 16, 1967
W. G. Hicks, Jackson, November 12, 1967
W. Lynn Hicks, McCaysville, May 18, 1967
J. T. Holt, Baxley, April 28, 1967
H. P. Hyde, Copperhill, Tennessee, October 6, 1967
Victoria I. Johnston, Brunswick, November 12, 1967
H. T. Jones, West Point, September 18, 1967
Claude T. Key, Atlanta, October 4, 1967
O. D. Middleton, Hinesville, June 16, 1967
W. E. Mobley, Macon, August 25, 1967
M. Fernan Nunez, Savannah, June 18, 1967
A. G. Pinkston, Jr., Glennville, August 24, 1967
David Henry Poer, Atlanta, June 14, 1967
Albert A. Rayle, Sr., Atlanta, May 12, 1967
D. S. Reese, Carrollton, August 9, 1967
Ivan B. Ross, Atlanta, January 11, 1968
Jose A. Samra, Hapeville, June 15, 1967
C. C. Shipp, Thomasville, July 13, 1967
Addison W. Simpson, Jr., Washington, May 11, 1967
Randolph Smith, Decatur, June 1, 1967
Phillip R. Stewart, Monroe, April 23, 1967
C. Griggs Thomason, East Point, November 17, 1967
O. R. Thompson, Macon, October 15, 1967
Charles B. Upshaw, Sr., Atlanta, May 10, 1967
E. Y. Walker, Milledgeville, August 3, 1967
William H. Wall, Blakely, July 19, 1967
John J. Westermann, Jr., Sea Island, February 7, 1968
M. W. Williams, Camilla, December 29, 1967

Specialty Society and Alumni Meetings, Luncheons, and Dinners

Specialty Societies have planned meetings, luncheons, and dinners for the membership of their organizations to be held in conjunction with the MAG Annual Session. These events are listed in the Official MAG Program, in the order of the date and time the event is scheduled—under *Related Events.* As these sessions are limited to the membership of the specialty society sponsoring the affair, they are not considered a part of the MAG Program and are printed in "box form" in the MAG Program to distinguish them from the MAG sessions.

MAG Social Events

Two social events are scheduled by MAG for the membership and their guests. The Richmond County Medical Society will host the membership at a Social Hour to be held on Monday evening, May 6, from 6:30 p.m. to 7:30 p.m., Swimming Pool Patio, on the second floor of the Augusta Town House.

The Medical Association of Georgia will honor its President at the traditional MAG President's Banquet to be held Monday evening, May 6, immediately following the Richmond County Medical Society Social Hour. The MAG President's Banquet will be a seated dinner with entertainment starting at 8:00 p.m. in the Embassy Room of the Augusta Town House. *As space for this banquet is limited, members are urged to purchase their banquet tickets on Sunday, May 5—at the MAG Registration Desk.* Accordingly, Banquet Tickets will be sold on a "first come—first served" basis.

A Social Hour limited to members of the MAG House of Delegates and their wives and Commercial Exhibitors and their wives will be held Sunday evening, May 5, at 6:00 p.m. in the Georgian Room on the second floor of the Augusta Town House. This Social Hour is sponsored by the Commercial Exhibitors in attendance at the 114th Annual Session and admission will be by ticket only. Tickets will be distributed to

members of the MAG House of Delegates and Exhibitors prior to the Social Hour.

MAG Golf Tourney

An MAG Golf Tourney will be held at the Augusta Country Club . . . 505 Milledge Road.

The dates of the tourney are Sunday, May 5, and Monday, May 6. To simplify matters and to guarantee your own foursome, it is suggested that you make your own foursome arrangements beforehand. If you do not have a group, the Club pro, Mr. Frank Carney, will help you get together with other MAG members. The Club pro will take your card at the end of the round and get your handicap. Prizes will be awarded on Monday night, May 6, at the MAG President's Banquet at 8:00 p m., Embassy Room, Augusta Town House. Note: Player will be responsible for the greens' fee. No entrance fee is required. To facilitate your entry in the tourney, please write to: Val Hastings, M.D., 1600 Winter Street, Augusta, Georgia, giving your name and indicating whether or not you will have a foursome.

Scientific Exhibits

Scientific Exhibits will be displayed adjacent to Commercial Exhibits in the French, Spanish and Italian Rooms of the second floor of the Augusta Town House. This Exhibit Hall will be used to gain entrance and exit to the main meeting room. The Scientific Exhibits are prepared by physicians who will be at their exhibits to discuss their presentation with the membership. All physicians are urged to visit each Scientific Exhibit in the interests of professional education. Awards for outstanding Scientific Exhibits will be presented at the final MAG General Business Session on Tuesday morning, May 7, at 9:00 a m. in the Embassy Room.

Commercial Exhibits

Approximately 50 Commercial Exhibits will be displayed in the French, Spanish, and Italian Rooms adjacent to the Main Meeting Room (Embassy Room). The Exhibit Hall will be used to gain both entrance and exit to the Main Meeting Room. These exhibits will provide technical information of importance on products and services available to the medical profession.

It is extremely important that every member visit each of these exhibits and register with the exhibitor. Your cooperation is requested in that these displays are designed specifically to benefit the profession. Commercial Exhibitors play an extremely important role in making the MAG Annual Session possible through their support of the meeting. Your MAG Commercial Exhibit Committee asks that physicians be sure to visit and register at all Commercial Exhibit booths.

The following firm has contributed funds to the Association for direct use in programming scientific speakers at this Annual Session: Eli Lilly and Co., Indianapolis, Indiana.

A list of Commercial Exhibitors already participating at this time in the MAG 114th Session is as follows:

Booth No.	*Name of Firm*
1	Stansell's Oxygen Service, Atlanta, Georgia
2	Sandoz Pharmaceuticals, Hanover, New Jersey
3	Delta Drug Corporation, Jacksonville, Florida
4	Mallinckrodt Pharmaceuticals, St. Louis, Missouri
5	Hoeber Medical Division, N. Y., N. Y. & Hagerstown, Md.
6	Loma Linda Foods, Riverside, California
7	Warren-Teed Pharmaceuticals, Inc., Columbus, Ohio
8	G. D. Searle and Co., Chicago, Illinois
9	The Stuart Company, Pasadena, California
10	Parke, Davis and Company, Detroit, Michigan
11	Life Insurance Company of Georgia, Atlanta, Georgia
12	Schering Laboratories, Union, New Jersey
13	Bristol Laboratories, Syracuse, New York
14	Flint Laboratories, Morton Grove, Illinois
15 & 16	International Business Machines, Augusta, Georgia
17	William P. Poythress and Co., Inc., Richmond, Virginia
18	W. B. Saunders Co., Philadelphia, Pennsylvania
19	CIBA Pharmaceutical Co., Summit, New Jersey
20	Ortho Pharmaceutical Corporation, Raritan, New Jersey
21	Smith, Miller and Patch, New York, New York
22	Emko Company, St. Louis
24	The Upjohn Company, Kalamazoo, Michigan
26	Siemens Medical of America, Inc., Addison, Illinois
27	S. J. Tutag and Company, Detroit, Michigan
28	Mead Johnson Laboratories, Evansville, Indiana
29	Ayerst Laboratories, New York, New York
34	Astra Pharmaceutical Products, Inc., Worcester, Mass.
35	Marks Surgical Supplies, Inc., Augusta, Georgia
36	Smith Kline and French Laboratories, Philadelphia, Pa.
37	Wachtel's Physician Supply, Savannah, Georgia
40	Dictaphone Corporation, Columbia, South Carolina
45	Lakeside Laboratories, Milwaukee, Wisconsin
46	Medco Products Company, Inc., Atlanta
47	Geigy Pharmaceuticals, Ardsley, New York
48	Coca-Cola Company, Atlanta, Georgia
49	A. H. Robins Company, Richmond, Virginia

Fifty Year Members

Physicians who have practiced medicine for 50 years will be honored at the MAG Annual Session by the award of a 50-Year Pin and Certificate. These awards will be presented at the MAG final General Business Session on Tuesday morning, May 7, at 9:00 a.m. in the Embassy Room. The following list contains the names of the members of the Medical Association who, as of the year 1968, have practiced medicine for 50 years. It does not record the names of physicians who have already received gold membership cards. This includes only those members in the class of 1918 who were also licensed in Georgia in 1918 as follows:

Mercer Blanchard	Columbus
Walter C. Goodpasture (Deceased)	Atlanta
Robert B. Goldin (Deceased)	Rockmart
John Erwin Penland	Waycross
Wyman Platt Sloan, Sr.	Atlanta
Joseph Yampolsky	Atlanta

MAG Voting Privileges

The MAG Constitution and Bylaws state that dues for Association members shall be payable on or before January 1 of the year for which they are levied. The Bylaws further state that any member whose name has not been reported for enrollment and whose dues for the current year have not been remitted to the MAG Headquarters Office on or before April 1 shall stand suspended until his name is properly reported and his dues for the current year properly remitted. The Secretary of each component county medical society must forward the physician's dues to MAG as the Association cannot under any circumstances receive such dues money directly from the member.

For voting purposes in the election of MAG officers at the Association Annual Session, only dues-paying members and certain other categories of membership will be allowed the privilege of voting. *If a member's MAG dues have not been forwarded to MAG prior to the time of an Annual Session, such member will not*

be allowed to vote unless that member pays his MAG dues to the County Society Secretary and the County Society Secretary gives such dues to the MAG Secretary during an Annual Session—but prior to the time of the official closing of the MAG Ballot Box, according to an MAG Council ruling. If such procedure is followed, the MAG Secretary, on receipt of a physician's MAG dues from the physician's County Medical Society Secretary, will then authorize the Teller's Committee to provide the physician with a ballot for voting purposes.

VOTING RULES

Bylaws, Chapter V, Election of Officers

BYLAWS, CHAPTER V, ELECTION OF OFFICERS. SECTION 3. METHOD. The President shall appoint a committee of not less than three Tellers immediately after the close of nominations, who shall have charge of the election. The Secretary shall have prepared in advance an official ballot and an official ballot box, which shall be kept in the custody of the Tellers Committee. One ballot only shall be given to each active voting member when he presents himself to cast his ballot. Each member and no other shall prepare his ballot and shall deposit it at that time in the locked ballot box.

The candidates for office receiving a majority of the votes shall be declared elected, but if no majority is received on the first ballot, the members present shall select by secret ballot the officer from the two candidates having the highest number of votes.

SECTION 4. TIME. Voting shall take place during the hours of the scientific program up to the beginning of the last day of the Annual Session. At that time the Committee of Tellers shall count the ballots and report their findings to the members.

AESCULAPIUS AWARD HONORS OUTSTANDING SCIENTIFIC EXHIBIT

The Medical Association of Georgia, in cooperation with Mead Johnson Laboratories, takes pleasure in announcing the AESCULAPIUS AWARD, to be presented to the author of the most outstanding scientific exhibit shown at the 1968 Annual Meeting.

The scientific exhibits will be judged by a committee of the Association and the winner of the AESCULAPIUS AWARD chosen by them. The winner will be presented with a certificate, suitably inscribed with the title of the exhibit and the author's name, and will receive a $200.00 cash prize donated by Mead Johnson Laboratories. Presentation will be made during the convention.

Physicians interested in submitting exhibits for showing at the Annual Meeting should make application to Medical Association of Georgia, 938 Peachtree Street, N.E., Atlanta, Georgia.

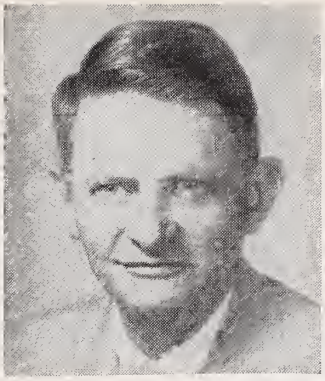
CALL FOR SCIENTIFIC EXHIBITS

114TH ANNUAL SESSION OF THE MEDICAL ASSOCIATION OF GEORGIA

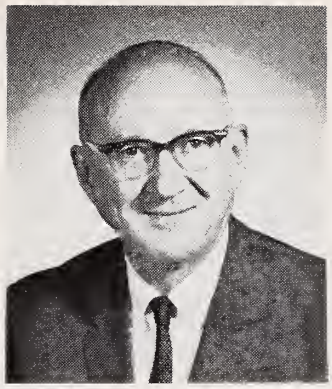
Augusta, Georgia, May 5-7, 1968

For Information and Applications, Write to:

John McClure, Jr., M.D., Chairman, MAG Scientific Exhibits Committee
938 Peachtree Street, N.E. • Atlanta, Georgia 30309

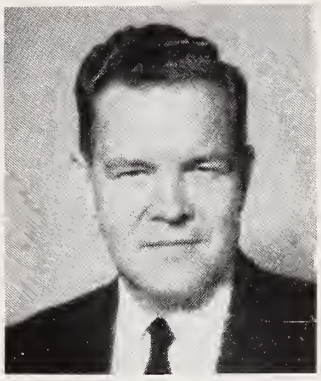


JOHN T. MAULDIN
President

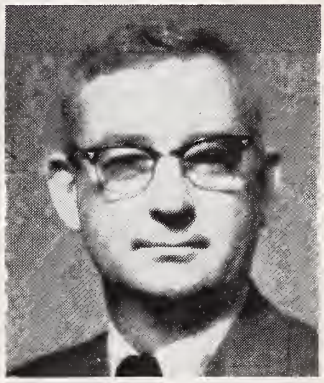


CHARLES R. ANDREWS
President-Elect

M. C. ADAIR
First Vice President



JOHN RHODES HAVERTY
Secretary



FLEMING L. JOLLEY
Second Vice President

Officers and Council of the Medical Association of Georgia

OFFICERS

President—John T. Mauldin, Atlanta (1968)*
President-Elect—Charles R. Andrews, Jr., Canton (1968)*
Immediate Past President—Walter E. Brown, Savannah (1970)*
Past President—George H. Alexander, Forsyth (1969)
Past President—J. G. McDaniel, Atlanta (1968)
First Vice President—M. C. Adair, Washington (1968)*
Second Vice President—Fleming L. Jolley, Atlanta (1968)*
Chairman of Council—F. G. Eldridge, Valdosta (1968)*
Secretary—J. Rhodes Haverty, Atlanta (1969)*
Treasurer—John S. Atwater, Atlanta (1968)*
Speaker of the House—J. Frank Walker, Atlanta (1968)*
Vice Speaker of the House—Harrison L. Rogers, Jr., Atlanta (1968)
Editor JMAG—Edgar Woody, Jr., Atlanta (1968)

COUNCILORS

District:
1—C. E. Bohler, Brooklet (1970)*
2—J. D. Bateman, Albany (1970)
3—J. T. Christmas, Vienna (1970)
6—Charles T. Cowart, LaGrange (1968)
7—Ralph N. Johnson, Rome (1968)
8—F. G. Eldridge, Valdosta (1968)
9—P. T. Scoggins, Commerce (1969)
10—William Rawlings, Sandersville (1969)

Bibb County Medical Society
Braswell E. Collins, Macon (1969)
Cobb County Medical Society
W. C. Mitchell, Smyrna (1969)
DeKalb County Medical Society
Floyd R. Sanders, Decatur (1969)
Fulton County Medical Society
Linton H. Bishop, Atlanta (1968)
J. Harold Harrison, Atlanta (1970)
Fleming L. Jolley, Atlanta (1969)
Georgia Medical Society
Lee Howard, Jr., Savannah (1970)
Muscogee County Medical Society
Luther H. Wolff, Columbus (1968)
Richmond County Medical Society
Harry D. Pinson, Augusta (1969)

VICE COUNCILORS

District:
1—L. H. Griffin, Claxton (1970)
2—Homer L. Lassiter, Arlington (1970)
3—John H. Robinson, Americus (1970)
6—E. E. Proctor, Newnan (1968)
7—David A. Wells, Dalton (1968)
8—J. W. Yeomans, Jesup (1968)
9—Robert S. Tether, Gainesville (1969)
10—Edgar J. Maxwell, Jr., Thomson (1969)
Bibb County Medical Society
W. H. M. Weaver, Macon (1969)
Cobb County Medical Society
Remer Y. Clark, Jr., Marietta (1969)
DeKalb County Medical Society
M. Freeman Simmons, Decatur (1969)
Fulton County Medical Society
J. Norman Berry, Sandy Springs (1968)
W. W. Moore, Jr., Atlanta (1970)
T. J. Anderson, Jr., Atlanta (1969)
Georgia Medical Society
W. W. Osborne, Savannah (1970)
Muscogee County Medical Society
Roy L. Gibson, Columbus (1968)
Richmond County Medical Society
J. L. Mulherin, Augusta (1969)

DELEGATES TO AMA AS OF JANUARY 1, 1968

Delegate	*Term Ending*
J. W. Chambers, LaGrange	(12-31-69)
John S. Atwater, Atlanta	(12-31-69)
J. Frank Walker, Atlanta	(12-31-68)
Preston D. Ellington, Augusta	(12-31-68)

Alternate Delegate	*Term Ending*
Neal F. Yeomans, Waycross	(12-31-69)
Henry S. Jennings, Gainesville	(12-31-69)
John Kirk Train, Savannah	(12-31-68)
F. W. Dowda, Atlanta	(12-31-68)

* *Executive Committee*

MAG 1968 Augusta Annual Session

Richmond County Medical Society Local Arrangements Committee

GENERAL CHAIRMAN

Preston D. Ellington

PUBLICITY CHAIRMAN

Julius Johnson

SPEAKERS' HOSPITALITY CHAIRMAN

Victor Moore

RCMS SOCIAL HOUR CHAIRMAN

Ronald Galloway

GOLF COMMITTEE CHAIRMAN

Val Hastings

AUXILIARY LIAISON CHAIRMAN

Stuart Prather

AUXILIARY

Mrs. W. A. Fuller, Augusta

Specialty Society Scientific Section Meeting Program Chairmen

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GEORGIA SOCIETY OF ANESTHESIOLOGISTS
Z. W. Gramling, M.D.
Talmadge Hospital
Augusta

CHEST

GEORGIA CHAPTER, AMERICAN COLLEGE OF CHEST PHYSICIANS & GEORGIA THORACIC SOCIETY & GEORGIA TB ASSOCIATION
Ronald F. Galloway, M.D.
1467 Harper St.
Augusta

DERMATOLOGY

GEORGIA SOCIETY OF DERMATOLOGISTS
C. Conrad Smith, M.D.
1125 Druid Park Ave.
Augusta

DIABETES

GEORGIA DIABETES ASSOCIATION
L. Harvey Hamff, M.D.
478 Peachtree St., N.E.
Atlanta

GENERAL PRACTICE

GEORGIA ACADEMY OF GENERAL PRACTICE
Robert E. Huie, M.D.
2223 Candler Rd.
Decatur

MEDICINE

GEORGIA SOCIETY OF INTERNAL MEDICINE & GEORGIA CHAPTER, AMERICAN COLLEGE OF PHYSICIANS & GEORGIA HEART ASSOCIATION
Ralph Murphy, M.D.
478 Peachtree St., N.E.
Atlanta

NEUROSURGERY

GEORGIA NEUROSURGICAL SOCIETY
Ernest F. Daniel, M.D.
1467 Harper St.
Augusta

OPHTHALMOLOGY AND OTOLARYNGOLOGY

GEORGIA SOCIETY OF OPHTHALMOLOGY & OTOLARYNGOLOGY
Claude L. Pennington, M.D.
829 First St.
Macon

ORTHOPEDICS

GEORGIA ORTHOPEDIC SOCIETY
Darius Flinchum, M.D.
340 Boulevard, N.E.
Atlanta

PATHOLOGY

GEORGIA ASSOCIATION OF PATHOLOGISTS
Hamil Murray, M.D.
Hall County Hospital
Gainesville

(Related Events)
E. V. Hastings, M.D.
St. Joseph Hospital
Augusta

PEDIATRICS

GEORGIA CHAPTER, AMERICAN ACADEMY OF PEDIATRICS
James W. Bennett, M.D.
1467 Harper St.
Augusta

PSYCHIATRY

GEORGIA PSYCHIATRIC ASSOCIATION
James Kenneth McDonald, M.D.
1445 Harper St.
Augusta

PUBLIC HEALTH

GEORGIA CHAPTER, AMERICAN ASSOCIATION OF PUBLIC HEALTH PHYSICIANS
W. D. Lundquist, M.D.
P. O. Box 6306
Savannah

RADIOLOGY

GEORGIA RADIOLOGICAL SOCIETY
Mark Brown, M.D.
Talmadge Hospital
Augusta

SURGERY

GEORGIA CHAPTER, AMERICAN COLLEGE OF SURGEONS
W. H. Moretz, M.D.
Talmadge Hospital
Augusta

THE PROGRAM

SATURDAY, MAY 4

RELATED EVENTS

(Not a part of Official Program)

NOTE: Make reservations in advance with Chairman if possible.

12:00 Georgia Chapter, American Academy of Pediatrics Social Hour and Luncheon
Towers Motor Hotel, Arthurian Room
James W. Bennett, Augusta, Chairman

1:30 Georgia Chapter, American Academy of Pediatrics Business Meeting
Towers Motor Hotel, Arthurian Room
James W. Bennett, Augusta, Chairman

2:30 Georgia Radiological Society Business Meeting
Augusta Town House, Georgian Room
A. A. Rayle, Atlanta, Chairman

7:30 Georgia Radiological Society Social Hour and Dinner
Pinnacle Club, Georgia Railroad Bank Building
A. A. Rayle, Atlanta, Chairman

7:30 Georgia Society of Dermatologists Social Hour and Banquet
Augusta Town House Motor Inn, Poolside (Social Hour); *Georgian Room* (Banquet)
C. Conrad Smith, Augusta, Chairman

7:30 Georgia Chapter, American Academy of Pediatrics Social Hour and Dinner
Town Tavern
James W. Bennett, Augusta, Chairman

4:30 Georgia Society of Anesthesiologists Business Meeting
Medical College of Georgia Auditorium
Z. W. Gramling, Augusta, Chairman

7:00 Georgia Society of Anesthesiologists Social Hour
(To be announced)
Z. W. Gramling, Augusta, Chairman

SUNDAY, MAY 5

RELATED EVENTS

(Not a part of Official Program)

NOTE: Make reservations in advance with Chairman if possible.

9:00 Georgia Radiological Society Golf
Augusta Country Club
Stephen W. Brown, Augusta, Chairman

9:00 Georgia Radiological Society Tours of Medical Center Radiological Facilities
Medical Center
W. H. Pool, Jr., Augusta, Chairman

9:00 Georgia Society of Dermatologists Case Presentations, Dermatology Division, Talmadge Memorial Hospital
Talmadge Memorial Hospital
C. Conrad Smith and J. Graham Smith, Augusta, Chairmen

10:00 Georgia Society of Ophthalmology and Otolaryngology Scientific Program
Augusta Town House Motor Inn, Boxwood Room
William S. Hagler, Atlanta, Presiding

10:00 "Diagnosis and Treatment of Macular Disease with the Use of Intravenous Fluorescein"
Paul C. Wetzig, Colorado Springs, Colorado

11:00 "Natural Course and Progression of Diabetic Retinopathy"
Matthew D. Davis, Madison, Wisconsin

10:00 Georgia Association of Pathologists Business Meeting
Augusta Town House Motor Inn, Walton Room
E. V. Hastings, Augusta, Chairman

12:00 Georgia Chapter, American College of Chest Physicians, Georgia Thoracic Society and Georgia Tuberculosis Association Luncheon and Business Meeting
Augusta Town House Motor Inn, Telfair Room
Ronald F. Galloway, Augusta, Chairman

12:00 Georgia Psychiatric Association Luncheon and Business Meeting
Augusta Town House Motor Inn, Fenwick Room
J. Kenneth McDonald, Augusta, Chairman

12:00 Georgia Pediatric Society Luncheon and Business Meeting
Augusta Town House Motor Inn, Embassy Room
James W. Bennett, Augusta, Chairman

12:00 Georgia Neurosurgical Society Luncheon
Augusta Country Club
Ernest F. Daniel, Augusta, Chairman

12:15 Georgia Society of Dermatologists Luncheon
Augusta Town House Motor Inn, Georgian Room
C. Conrad Smith, Augusta, Chairman

12:30 Georgia Association of Pathologists Luncheon
Augusta Town House Motor Inn, Walton Room
E. V. Hastings, Augusta, Chairman

12:30 Georgia Society of Ophthalmology and Otolaryngology Luncheon and Business Meeting
Towers Motel, Arthurian Room
Claude L. Pennington, Macon, Chairman

2:00 Georgia Neurosurgical Society Scientific Meeting
Medical College of Georgia
Ernest F. Daniel, Augusta, Chairman
Speakers
Louis Hazouri, Columbus; H. Dale Richardson, Atlanta; Ellis B. Keener, Decatur; Fleming L. Jolley, Atlanta; and Marshall Allen, Augusta

SUNDAY AFTERNOON, MAY 5

2:00 Pediatric and Pathology Joint Section Meeting*
(ALL PHYSICIANS INVITED)
Augusta Town House Motor Inn, Embassy Room
PRESIDING
Martin H. Smith, Gainesville

2:00 INTRODUCTION AND WELCOME

2:05 THE INFECTING VIRUS AND THE RESPONSIVE HOST
Samuel L. Katz, Boston, Massachusetts

2:45 VIRAL RESPIRATORY DISEASES
Henry G. Cramblett, Columbus, Ohio

3:25 VIEW EXHIBITS

3:40 PRESENT STATUS OF MUMPS VACCINE
Philip Brunell, New York City

4:20 PANEL
MODERATOR
Andre J. Nahmias, Atlanta
DISCUSSORS
Samuel L. Katz, Boston, Massachusetts
Henry G. Cramblett, Columbus, Ohio
Philip Brunell, New York City
Mr. Earl E. Long, Atlanta

2:00 General Practice and Psychiatry Joint Section Meeting
(ALL PHYSICIANS INVITED)
Augusta Town House Motor Inn, Georgian Room
PRESIDING
J. Kenneth McDonald, Augusta

2:00 ABORTION FOR THE EMOTIONALLY DISTURBED?
Sheldon Cohen, Atlanta
DISCUSSED BY
William S. Boyd, Augusta

3:15 PANEL: WHAT DOES THE PRACTITIONER WANT FROM THE PSYCHIATRIST AND WHAT CAN HE OFFER?
MODERATOR
J. Kenneth McDonald, Augusta
PANELISTS
August S. Yochem, Atlanta
Joseph S. Skobba, Atlanta
Irving D. Hellenga, Toccoa
Don Schmidt, Cedartown

** Seminar Services Unit of the National Communicable Disease Center, Atlanta, with the cooperation of the Georgia Chapter, American Academy of Pediatrics, arranged the above program.*

2:00 Dermatology and Public Health Joint Section Meeting
(ALL PHYSICIANS INVITED)
Augusta Town House Motor Inn, Walton Room
PRESIDING
C. Conrad Smith, Augusta
J. Graham Smith, Augusta

2:00 OCCUPATIONAL DERMATITIS FROM PLASTICS
Marcus M. Key, Cincinnati, Ohio

2:45 TREATMENT OF SKIN CANCER
Wiley M. Sams, Miami, Florida

3:30 VIEW EXHIBITS

4:00 DERMATOPHILOSIS
Thomas F. Goodman, Augusta

4:15 CHRONIC ERYTHEMA NODOSUM
Robert M. Fine, Decatur

4:30 BASAL CELL CARCINOMA IN A VACCINATION SCAR
H. Jordan Whyte, Atlanta

2:00 Radiology Section Meeting
(ALL PHYSICIANS INVITED)
Augusta Town House Motor Inn, Oak Room
PRESIDING
Ted F. Leigh, Atlanta

2:00 BREAST AND CERVICAL CANCER—AN AUDIT OF A THERAPY PRACTICE
Herbert M. Olnick, Macon

2:15 CURRENT CONCEPTS OF CHOLANGIOGRAPHY
Robert E. Wise, Boston, Massachusetts

2:35 BIOLOGICAL MECHANISMS OF RADIATION PROTECTION
Sherwood M. Reichard, Augusta

2:50 VIEW EXHIBITS

3:05 ARTERIO-VENOUS MALFORMATIONS OF THE CAROTID CIRCULATION
Daniel R. Scullin, Atlanta
Ronald L. King, Atlanta

3:30 COLOR SUBTRACTION OF RADIOGRAPHS
Robert E. Wise, Boston, Massachusetts

4:00 INTERESTING FILM PANEL
MODERATOR
H. H. McGee, Savannah
PANEL: (To be announced)

2:00 Orthopedic Section Meeting
(ALL PHYSICIANS INVITED)
Augusta Town House Motor Inn, Fenwick Room
PRESIDING
James L. Becton, Augusta

2:00 THUMB REPLACEMENT
Waldo E. Floyd, Macon
DISCUSSORS: (To be announced)

2:30 USE OF THE V-W INCISION IN HAND SURGERY
James L. Becton, Augusta
DISCUSSORS: (To be announced)

3:00 PIGEON TOES—SYMPOSIUM
MODERATOR
Robert R. McKnight, Augusta
PANELISTS
J. Hiram Kite, Atlanta
Floyd E. Bliven, Jr., Augusta

3:30 VIEW EXHIBITS

4:00 EARLY SURGICAL TREATMENT FOR RHEUMATOID ARTHRITIS
Ronald L. Linscheid, Rochester, Minnesota

4:30 OPERATIVE VERSUS NONOPERATIVE TREATMENT FOR FEMORAL FRACTURES
C. William Brown, Augusta
DISCUSSORS: (To be announced)

2:00 Ophthalmology and Otolaryngology Section Meeting
(ALL PHYSICIANS INVITED)
Augusta Town House Motor Inn, Boxwood Room
PRESIDING
William S. Hagler, Atlanta

2:00 TREATMENT OF DIABETIC RETINOPATHY BY LIGHT COAGULATION
Paul C. Wetzig, Colorado Springs, Colorado

3:00 PRESENT TRENDS IN OTOLOGY
G. Dekle Taylor, Jacksonville, Florida

4:00 CONTINUATION OF DISCUSSION OF DIABETIC RETINOPATHY AND SUMMARY OF THE DAY'S TALKS
Matthew D. Davis, Madison, Wisconsin
Paul C. Wetzig, Colorado Springs, Colorado

4:45 QUESTION AND ANSWER PERIOD

2:00 Chest Section Meeting
(ALL PHYSICIANS INVITED)
Augusta Town House Motor Inn, Telfair Room
PRESIDING
Robert G. Ellison, Augusta

2:00 TUBERCULOSIS PROPHYLAXIS
Rufus F. Payne, Augusta

2:40 QUESTIONS AND DISCUSSION

2:50 RECURRENT LOCALIZED PULMONARY INFECTIONS
Will C. Sealy, Durham, North Carolina

3:30 QUESTIONS AND DISCUSSION

3:40 VIEW EXHIBITS

3:50 PULMONARY EMBOLISM
Thomas J. Yeh, Savannah

4:30 QUESTIONS AND DISCUSSION

SUNDAY, MAY 5

5:00 MAG General Business Session
(ALL MAG AND AUXILIARY MEMBERS AND GUESTS INVITED)
Augusta Town House Motor Inn, Embassy Room
PRESIDING
John T. Mauldin, Atlanta, President Medical Association of Georgia
NOMINATIONS OF OFFICERS AND COUNCILORS
(Announcement of Tellers Committee)
President-Elect
Second Vice President
Sixth District Councilor (To serve until 1971
Sixth District Vice Councilor (To serve until 1971)
Seventh District Councilor (To serve until 1971).
Seventh District Vice Councilor (To serve until 1971)
Eighth District Councilor (To serve until 1971)
Eighth District Vice Councilor (To serve until 1971)
Tenth District Councilor (To fill unexpired term of Addison W. Simpson) (To serve until 1969)
Tenth District Vice Councilor (To fill unexpired term of William Rawlings) (To serve until 1969)
Fulton County Medical Society Councilor (To serve until 1971)
Fulton County Medical Society Vice Councilor (To serve until 1971)
Fulton County Medical Society Vice Councilor (To fill the unexpired term of Frank L. Wilson) (To serve until 1970)
Muscogee County Medical Society Councilor (To serve until 1971)
Muscogee County Medical Society Vice Councilor (To serve until 1971)
AMA Delegate (Term beginning January 1, 1969 and expiring December 31, 1970) (For office held by J. Frank Walker)
AMA Alternate Delegate (Term beginning January 1, 1969 and expiring December 31, 1970) (For office held by John Kirk Train)
AMA Delegate (Term beginning January 1, 1969 and expiring December 31, 1970) (For office held by Preston D. Ellington)
AMA Alternate Delegate (Term beginning January 1, 1969 and expiring December 31, 1970) (For office held by F. W. Dowda

Nominations for Awards:

General Practitioner of the Year Award (To be voted on by House of Delegates)

SUNDAY EVENING, MAY 5

RELATED EVENTS

(Not a part of Official Program)

NOTE: Make reservations in advance with Chairman if possible.

6:30 Medical College of Georgia Alumni Association Social Hour and Dinner
Augusta Country Club
(Chairman—to be announced)

6:30 Emory University Medical Alumni Association Social Hour and Dinner
(To be announced)
(Chairman—to be announced)

SUNDAY EVENING, MAY 5

6:00 Delegates and Exhibitors Social Hour
Augusta Town House Motor Inn, Georgian Room

MONDAY MORNING, MAY 6

RELATED EVENTS

(Not a part of Official Program)

NOTE: Make reservations in advance with Chairman if possible.

7:30 GaMPAC Board of Directors Breakfast
Augusta Town House Motor Inn, Fenwick Room
Preston Ellington, Augusta, Chairman

8:00 Georgia Diabetes Association Breakfast
Augusta Town House Motor Inn, Walton Room
Harvey Hamff, Atlanta, Chairman
Speaker: Robert Bradley, Boston, Massachusetts

MONDAY MORNING, MAY 6

9:00 MAG General Business Session and House of Delegates Meeting
(ALL MAG AND AUXILIARY MEMBERS AND GUESTS INVITED)
Augusta Town House Motor Inn, Embassy Room

8:45 MAG Delegates Registration
Embassy Room Entrance

9:00 General Business Session

PRESIDING
John T. Mauldin, Atlanta, President Medical Association of Georgia

Invocation
Reverend John G. Parks, Jr., Pastor First Presbyterian Church, Augusta

Welcome
Stuart H. Prather, Jr., President Richmond County Medical Society

Greetings
Honorable George Sancken, Jr., Mayor City of Augusta

Our Association Future for 1968-69
Charles R. Andrews, Jr., Canton, President-Elect Medical Association of Georgia

Report of the Auxiliary
Mrs. Hayward S. Phillips, Augusta President-Elect

MAG Memorial Service

House of Delegates Meeting

PRESIDING
J. Frank Walker, Atlanta Speaker of the House

Order of Business (See Delegates Handbook)

10:30 MAG General Assembly
(ALL MAG AND AUXILIARY MEMBERS AND GUESTS INVITED)
Augusta Town House Motor Inn, Embassy Room

PRESIDING
John T. Mauldin, Atlanta, President Medical Association of Georgia

10:30 Panel: Efficiency in Medical Practice

Moderator
J. Rhodes Haverty, Atlanta

Panelists
Krikor K. Soghikian, Oakland, California
Amos Johnson, Garland, North Carlina
Mr. Richard Bramblett, Augusta

11:30 Politics Without Doctors Is Bad Medicine
Honorable Paul J. Fannin United States Senator from Arizona

Sponsored by the Georgia Medical Political Action Committee

MONDAY AFTERNOON, MAY 6

2:30 MAG Reference Committees
Augusta Town House Motor Inn

Reference Committee No. 1:
Boxwood A Room

Reference Committee No. 2:
Boxwood B Room

Reference Committee No. 3:
Oak Room

Reference Committee No. 4:
Walton Room

Reference Committee No. 5:
Fenwick Room

MONDAY AFTERNOON, MAY 6

RELATED EVENTS

(Not a part of Official Program)

NOTE: Make reservations in advance with Chairman if possible.

12:00 Georgia Chapter, American College of Surgeons Social Hour and Luncheon
Town Towers
Harry D. Pinson, Augusta, Chairman

12:00 Georgia Society of Internal Medicine, Georgia Chapter, American College of Physicians and Georgia Heart Association Business Meeting and Luncheon
Pinnacle Club, Georgia Railroad Bank Building
Ralph Murphy, Atlanta and
Alex T. Murphy, Augusta, Co-Chairmen

9:00 Georgia Orthopedic Society Fracture Conference
University Hospital, Second Floor Class Room
Charles Freeman, Augusta, Chairman
(All Physicians Invited)

12:00 Georgia Orthopedic Society Luncheon
Medical College of Georgia, Student Union Building
Elvin Saunders, Augusta, Chairman
Speaker: Donald L. Linscheid, Rochester, Minnesota on "Late Surgical Treatment for Rheumatoid Arthritis" (All Physicians Invited. No reservations necessary.)

2:00 Georgia Orthopedic Society Clinical Session
Talmadge Memorial Hospital, Seventh Floor Conference Room
Floyd E. Bliven, Jr., Augusta, Chairman
(Physicians are urged to bring x-rays and problem questions)
Panel: (to be announced)

MONDAY AFTERNOON, MAY 6

2:30 Internal Medicine Section Meeting
(ALL PHYSICIANS INVITED)
Augusta Town House Motor Inn, Embassy Room
PRESIDING
Tully T. Blalock, Atlanta

2:30 A Rheumatologist's Evaluation of Orthopedic Measures in the Management of Arthritis
Currier McEwen, New York City
Introduced by Vernon Powell and John Slade
Georgia Chapter, Arthritis Foundation

3:00 Clinical Application of Cardiac Pacemakers
Charles F. Wooley, Columbus, Ohio
Introduced by C. Daniel Cabaniss, Georgia Heart Association

3:30 New Aspects of Diabetic Mellitus—Research and Treatment
Robert Bradley, Boston, Massachusetts
Introduced by Harvey Hamff, Georgia Diabetes Association
(To be sponsored by Merck, Sharp and Dohme Postgraduate Program)

4:00 View Exhibits

4:15 Panel: Ischemic Heart Disease, Arthritis and Diabetes Mellitus
Moderators
Harvey Hamff, Atlanta
C. Daniel Cabaniss, Atlanta
Vernon Powell, Atlanta
Panelists
Currier McEwen, New York City
Charles F. Wooley, Columbus, Ohio
Robert Bradley, Boston, Massachusetts

2:30 Surgery Section Meeting
(ALL PHYSICIANS INVITED)
Augusta Town House Motor Inn, Teakwood Room
PRESIDING
Jerry P. Woodhall, Macon

2:30 Development of Gallstones
Nathan Womack, Chapel Hill, North Carolina

3:00 Physiologic Indications for Surgical Treatment of Peptic Ulcer
Edgar Poth, Galveston, Texas

3:30 Clinical Problems in Renal Transplantation
Garland Perdue, Atlanta

3:45 Laboratory Problems in Renal Transplantation
Arthur L. Humphries, Jr., Augusta

4:00 The Nature of Splenomegaly
Nathan Womack, Chapel Hill, North Carolina

4:30 Controversial Aspects of Preoperative Colon Antisepsis
Edgar Poth, Galveston, Texas

MONDAY, MAY 6

6:30 Richmond County Medical Society Social Hour
(ALL MAG MEMBERS AND THEIR WIVES WELCOME)
Sponsored by the Membership of Richmond County Medical Society
Augusta Town House Motor Inn, Swimming Pool Patio

8:00 MAG President's Banquet
Augusta Town House Motor Inn, Embassy Room

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Vitamin B_6	7.5 mg
Vitamin B_{12}	50 mcgm
Vitamin C	200 mg
Niacinamide	30 mg
Folic Acid	0.05 mg
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*

anticostive, *adj.* (*anti* opposed to + *costive* causing constipation.) Against constipation. (Now isn't that a good idea in an iron-containing hematinic? We'll send you samples if you'll send a request on your Rx blank, addressed to Department 150.)

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TUESDAY MORNING, MAY 7

9:00 MAG General Business Session and House of Delegates Second Meeting
(ALL MAG AND AUXILIARY MEMBERS AND GUESTS INVITED)
Augusta Town House Motor Inn, Embassy Room

8:45 MAG DELEGATES REGISTRATION
Embassy Room Entrance

PRESIDING
John T. Mauldin, Atlanta, President Medical Association of Georgia

PRESENTATION OF 50 YEAR CERTIFICATES
Walter E. Brown, Savannah Immediate Past President Medical Association of Georgia

PRESENTATION OF SCIENTIFIC EXHIBIT AWARDS
John N. McClure, Atlanta, Chairman Scientific Awards Committee

PRESENTATION OF GENERAL PRACTITIONER OF THE YEAR AWARD
Robert E. Huie, Decatur, President Georgia Academy of General Practice

PRESENTATION OF MAG CERTIFICATES OF APPRECIATION
J. Rhodes Haverty, Atlanta, Secretary Medical Association of Georgia

PRESENTATION OF HARDMAN AWARD
Charles R. Andrews, Jr., Canton, President-Elect Medical Association of Georgia

PRESENTATION OF MAG DISTINGUISHED SERVICE AWARD
John T. Mauldin, Atlanta, President Medical Association of Georgia

PRESENTATION OF AMA CERTIFICATES OF HUMANITARIAN SERVICE
J. Rhodes Haverty, Atlanta, Secretary Medical Association of Georgia

SELECTION OF SITE FOR MAY 1970 ANNUAL SESSION

ANNOUNCEMENT OF MAG ELECTION RESULTS
Chairman, Tellers Committee

INSTALLATION OF 1968-69 OFFICERS
John T. Mauldin, Atlanta, Immediate Past President Medical Association of Georgia

HOUSE OF DELEGATES SECOND MEETING
PRESIDING
J. Frank Walker, Atlanta Speaker of the House

ORDER OF BUSINESS (See Delegates Handbook)

ADJOURNMENT OF THE HOUSE

ADJOURNMENT OF 114TH ANNUAL SESSION

Guest Speakers

SAMUEL L. KATZ, M.D.

Boston, Massachusetts

SAMUEL L. KATZ, M.D., Assistant Professor of Pediatrics, Harvard Medical School, and Co-Director, Beth Israel Hospital-Children's Hospital Medical Center combined Infectious Disease Training Program, will open one of the first scientific sessions of the 114th Annual Session of the Medical Association of Georgia.

Dr. Katz received his M.D. degree cum laude from Harvard Medical School in 1952. After his medical internship he received pediatric residency training at Boston's Children's Hospital Medical Center, Massachusetts General Hospital, and St. Mary's Hospital in London, England. He also received virology research training under Dr. John F. Enders and has been associated with him since 1961. In September of this year Dr. Katz will become Professor and Chairman of the Department of Pediatrics, Duke University School of Medicine.

Dr. Katz's clinical and laboratory interests in virus infection are reflected in the title of his presentation, "The Infecting Virus and the Responsive Host," to be made at 2:00 P.M., Sunday, May 5, before the Pediatric and Pathology Joint Section Meeting.

This presentation will briefly review the structure and behavior of viruses in the context of current concepts of their role in human infections. After a consideration of those features of the immune response which are involved in resistance, recovery and prevention of reinfection, an attempt will be made to relate the interactions of virus and host responses to the clinical manifestations of viral disease.

HENRY G. CRAMBLETT, M.D.

Columbus, Ohio

HENRY GAYLORD CRAMBLETT, M.D., of Columbus, Ohio, is Professor and Chairman of the Department of Medical Microbiology and Professor of Pediatrics at Ohio State University and is also Executive Director of the Children's Hospital Research Foundation in Columbus.

Dr. Cramblett graduated from the University of Cincinnati College of Medicine in 1953. He served his internship at Boston City Hospital on the Harvard Medical Service and completed a residency in pediatrics at Children's Hospital in Cincinnati. He has taught in the Department of Pediatrics at State University of Iowa and at Bowman Gray School of Medicine. Dr. Cramblett went to Ohio State in 1964.

Dr. Cramblett is a former president of the Southern Society for Pediatric Research. He is a Diplomate of the American Board of Pediatrics and of the American Board of Microbiology as well as a member of the American Academy of Pediatrics, American Pediatric Society, Society for Pediatric Research, American Society for Microbiology, Society for Experimental Biology and Medicine, Infectious Diseases Society of America, and a Fellow of the American Association for the Advancement of Science.

His presentation, "Viral Respiratory Diseases," will be made at 2:45 P.M., May 5, before the Pediatric and Pathology Joint Section Meeting. A short resume follows:

The viruses which cause respiratory disease in infants, children and adults will be discussed. The properties of the viruses, the characteristics of the disease which they cause, and epidemiologic data regarding these viruses will be reviewed. Approaches to control of viral respiratory diseases will be put in perspective.

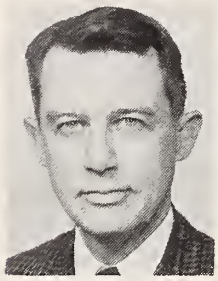
PHILIP A. BRUNELL, M.D.

New York, New York

PHILIP A. BRUNELL, M.D., Assistant Professor of Pediatrics at New York University School of Medicine, will speak to the Pediatrics and Pathology Joint Section Meeting on Sunday, May 5, at 3:40 P.M.

Dr. Brunell received his medical degree from the University of Buffalo School of Medicine in 1957. He served a rotating internship at E. J. Meyer Memorial Hospital in Buffalo and a residency in pediatrics at Children's Hospital in Buffalo. From 1961 to 1964 he was Instructor in Pediatrics at Emory and Extern in Pediatrics at Grady Memorial Hospital in Atlanta. He is a member of the American Academy of Pediatrics and the American Society for Microbiology and a Diplomate of the American Board of Pediatrics.

Dr. Brunell will speak on the "Present Status of Mumps Vaccine."



MARCUS M. KEY, M.D.

Cincinnati, Ohio

MARCUS M. KEY, M.D., is Chief, Clinical Services Section, National Center for Urban and Industrial Health Occupational Health Program in Cincinnati, and is Acting Chief, Appalachian Laboratories for Occupational Respiratory Diseases, West Virginia Medical Center in Morgantown, West Virginia. He received his M.D. degree in 1952 from the Columbia College of Physicians and Surgeons and the M.I.H. from the Harvard School of Public Health in 1954.

Dr. Key interned at the U. S. Public Health Service Hospital in Boston and received specialty training at the Harvard School of Public Health in Boston, the Presbyterian Hospital, New York City, and the Cincinnati General Hospital. He is a Diplomate of the American Board of Dermatology and the American Board of Preventive Medicine (Occupational Medicine). He is a member of the American Academy of Dermatology, Industrial Medical Association and American Conference of Governmental Industrial Hygienists.

Dr. Key is Assistant Clinical Professor of Dermatology and Clinical Instructor in Industrial Medicine at the College of Medicine, University of Cincinnati. An abstract of his presentation, "Occupational Dermatitis from Plastics," which will be given Sunday, May 5, at 2:00 P.M. before the Dermatology and Public Health Joint Section Meeting, follows:

> The parasitic causes of itching have been almost eliminated, but we have not yet solved the problem of industrial dermatitis ("$200,000,000 itch"). Using examples from the manufacture of plastics products familiar to the consumer, the diagnosis, treatment, and prevention of occupational dermatitis are reviewed.
>
> Dermatitis is seldom encountered from the completely cured or polymerized product, so the consumer is rarely affected. Industrial workers who contact the components used in manufacture or application of certain plastics (formaldehyde, epoxy, and polyester resins) are chiefly affected. Occupational dermatitis is easy to diagnose and is amenable to local therapy, but prevention is complicated by the complexity of our technology, inadequate labelling, and poor communication between the practicing physician and the work place.

WILEY M. SAMS, M.D.

Miami, Florida

WILEY M. SAMS, M.D., Clinical Professor of Dermatology at the University of Miami, is a Kentuckian by birth who had his medical and specialty training at the University of Michigan. He is a Diplomate of the American Board of Dermatology, a past chairman of the AMA Section on Dermatology, a past president of the American Academy of Dermatology and a past president of the American Dermatological Association.

Dr. Sams continues in private practice and finds himself in a community and age group in which skin cancer and precancerous lesions form an increasing amount of the work which he sees from day to day. His talk on "Treatment on Skin Cancer" will take place at 2:45 P.M. on Sunday, May 5, before the Joint Meeting of the Dermatology and Public Health Sections. An abstract follows:

> The primary physician who examines a patient with skin cancer may either treat or refer the patient for the treatment of this disorder. An increasing number of people in the older age group means that this will be a problem that will present itself with greater frequency. Skin cancer is a curable disorder if treated early. Effective programs of treatment both by surgical measures and radiation therapy have been extensively used in the past 50 years. Newer methods of treatment and re-evaluation of older methods continue to appear in the medical literature. These articles are widely read because this is a common disorder and the busy physician, no matter what his field of interest, must address himself to the problems involved.
>
> Surgeons, radiation therapists and dermatologists are the physicians who have taken the greatest interest in the subject. Many early forms of skin cancer lend themselves to adequate and satisfactory treatment as an office procedure which does not incur a period of disability or create a major expense for the patient involved. The physician who is willing to develop an interest in the procedures involved can learn to choose the method which will be most appropriate for his patient. Cure rates of approximately 95 per cent are obtained with the majority of therapeutic procedures and less than two per cent of the patients die as a result of skin cancer. The physician who is familiar with all of the available therapeutic procedures is in the best position to select the most appropriate method of treatment. He should learn which cases to refer when the therapeutic procedure indicated is one with which he is not familiar or one which is beyond his capabilities in a given field. My discussion will be projected to cover the choice of treatment.

ROBERT E. WISE, M.D.

Boston, Massachusetts

ROBERT E. WISE, M.D., Chairman of the Department of Diagnostic Radiology at the Lahey Clinic Foundation in Boston, will speak before the Radiology Section Meeting twice on Sunday, May 5.

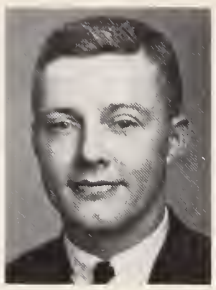
Dr. Wise received his medical degree from the University of Maryland School of Medicine. He is a Diplomate of the American Board of Radiology and a member of the American Roentgen Ray Society, Radiological Society of North America, American College of Radiology, and the American Gastro-Enterological Society.

Dr. Wise will speak at 2:15 P.M. on "Current Concepts of Cholangiography":

> Since the advent of intravenous cholangiography 15 years ago, it has become an accepted procedure for the diagnosis of diseases affecting the common bile duct, and to a limited extent, the gallbladder. In this period, certain clear-cut indications have evolved. These will be presented with respect to both the pre- and postcholecystectomy patient. Limitations, as with any procedure, are inherent.
>
> Some remain fearful of the procedure, but properly administered, the drug is now considered a safe contrast agent with a minimal reaction rate.
>
> The current concepts of intravenous cholangiography as well as allied methods of examining the bile ducts will be presented.

Dr. Wise will speak again at 3:30 P.M. on "Color Subtraction of Radiographs":

> A unique system of contrast enhancement of radiographs by means of color addition has been developed. The greatest value appears to lie in medical illustration and teaching but in approximately five to ten per cent of cases in which it has been applied, a clinical advantage had been found.
>
> The technique and results will be presented.

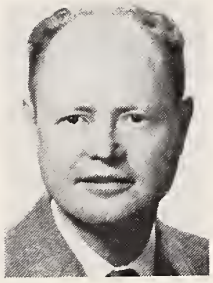


RONALD LEE LINSCHEID, M.D.

Rochester, Minnesota

RONALD LEE LINSCHEID, M.D., Consultant in Orthopedic and Hand Surgery at the Mayo Clinic, received his M.D. degree from the University of Kansas School of Medicine. He interned in Minneapolis at the University of Minnesota Hospitals, and spent four years as a Fellow in Orthopedic Surgery at the Mayo Graduate School of Medicine. He received an M.S. degree from the University of Minnesota in 1963. An abstract of his presentation, "Early Synovectomy in Rheumatoid Arthritis," scheduled for Sunday, May 5, at 4:00 P.M. before the Orthopedic Section Meeting follows:

> The use of surgical synovectomy in rheumatoid arthritis is a controversial subject. Although first performed largely on the knee joint, because of its accessibility and large size, surgical synovectomy is now carried out on many joints of the body affected by rheumatoid arthritis. It is generally agreed that surgical synovectomy should only be carried out in those patients in whom good medical control of the inflammatory changes in the joint cannot be established.
>
> From a theoretical standpoint, synovectomy has the following advantages: 1) removal of the inflammed synovium and the joint debris 2) removal of the lysozymal enzymes from the degenerating leukocytes secondary to the inflammation and 3) the subsequent improvement in the lubricating properties of the synovial fluid. The efficacy of this procedure as is readily seen is largely dependent upon the adequacy of the procedure and assumption that the regenerating synovium will be considerably less involved by the inflammatory response. It is also hoped that by performing early synovectomy the progressive joint destruction and the deformities attendent upon the forces acting about the joint will be lessened.
>
> From a practical standpoint, the aching discomfort of rheumatoid arthritis is often relieved by early synovectomy and subjectively, most patients' response is enthusiastic. Some of the surgical considerations and results will be shown by illustrations.



PAUL C. WETZIG, M.D.

Colorado Springs, Colorado

PAUL C. WETZIG, M.D., received his medical degree from the University of Colorado Medical School in Denver. He served his residency at the New York Hospital Cornell Medical Center in New York City and has been in the private practice of ophthalmology since 1953 at the Colorado Springs Eye Clinic.

Dr. Wetzig will speak before the Ophthalmology and Otolaryngology Section Meeting Sunday, May 5, at 2:00 P.M. on the "Treatment of Diabetic Retinopathy by Light Coagulation." A brief summary:

> The treatment of diabetic retinopathy by light coagulation is a purely local concept of treating proliferative retinopathy by destroying bleeding vessels and progressive proliferative tissue within the eye. The indications, technique, and results will be presented by color photographs.

Dr. Wetzig will also speak at 10:00 A.M. Sunday morning to the Georgia Society of Ophthalmology and Otolaryngology on "Diagnosis and Treatment of Macular Disease with the Use of Intravenous Fluorescein."

G. DEKLE TAYLOR, M.D.

Jacksonville, Florida

G. DEKLE TAYLOR, M.D., received his medical degree from the University of Michigan Medical School and completed a residency in otolaryngology at the University Hospital in Ann Arbor, Michigan. He also did postgraduate work in otolaryngology at the University Hospital. He is now Chairman of

the Department of Otolaryngology of the Duval Medical Center in Jacksonville, Florida.

Dr. Taylor is a member of the American Academy of Ophthalmology and Otolaryngology, the American Laryngological, Rhinological and Otological Society, American College of Surgeons and the American Otological Society.

He will speak Sunday afternoon at 3:00 P.M. before the Ophthalmology and Otolaryngology Section Meeting on "Present Trends in Otology."

An attempt will be made to bring a view of the present trends in otology in focus with the past and future. The discussion will be broad and practical in its concept. The essayist will take license in emphasizing certain subjects of interest to himself. Pertinent case presentations will be given. The social evolution of otology will be discussed along with our obligations to our patients of the present and future.

MATTHEW D. DAVIS, M.D.

Madison, Wisconsin

MATTHEW D. DAVIS, M.D., Associate Clinical Professor of Surgery (Ophthalmology) at the University of Wisconsin Medical School, received his medical degree from the University of Pennsylvania. He completed his internship and residency in ophthalmology at the University of Wisconsin Hospitals, and has been a member of the Ophthalmology Division at Wisconsin since 1956.

Dr. Davis will discuss "Diabetic Retinopathy" on Sunday, May 5, at 4:00 P.M. before the Ophthalmology and Otolaryngology Section Meeting. A brief summary follows:

A summary of the natural evolution of diabetic retinopathy, particularly its proliferative phase, based on study of over 400 patients during the past five years will be presented. The presentation will emphasize the important part played by vitreous contraction in the proliferative phase of diabetic retinopathy and will emphasize the hazards entailed in any uncontrolled study of treatment for diabetic retinopathy.

WILL C. SEALY, M.D.

Durham, North Carolina

WILL C. SEALY, M.D., is a native of Roberta, Georgia, who received his M.D. degree from Emory. He completed his internship and residency in surgery at Duke Hospital in Durham, North Carolina. He has taught at Duke since 1946 and has been Professor of Thoracic Surgery since 1956.

Dr. Sealy is a member of the advisory committee of the American College of Surgeons, a member of the American Association for Thoracic Surgery, the American Federation for Clinical Research, American Surgical Association, President of the Southern Thoracic Surgical Association, and Committee Chairman of the Postgraduate Program of the Society of Thoracic Surgeons.

Dr. Sealy will speak to the Chest Section Meeting on Sunday, May 5, at 2:50 P.M. on "Recurrent Localized Pulmonary Infections."

Recurrent localized pulmonary infections are problems in which surgery is frequenty indicated. I have found that there are two general categories of patients with this type of infection. The first category consists of two subdivisions. In one, there are a group that have overt deficiencies in their immune mechanism, and even a trivial infection may, on occasion, cause enough damage to the lung that recurrent infection in the same area frequently occurs. The second subdivision of patients in this category are the ones who have what are apparently normal immune mechanisms, but who develop a severe infection that again may damage the bronchi. It may or may not damage the bronchi in the remainder of the lung to the point that it is the site of repeated infections.

The second broad category of patients are those who have some mechanical factor in their tracheobronchial tree that predisposes to infection. This includes, particularly, the middle lobe syndrome. In the middle lobe, as well as elsewhere, obstruction from various regions can be a factor in the development of irreversible changes that make the lung the site of repeated infections. In the middle lobe and sometimes in the lingula, there are normal anatomical differences between individuals that may make one more prone to infection than the other. It is postulated in this group that a completely separate middle lobe or lingula may make the lobe unlikely to have the benefit of collateral ventilation in the excavation of retained secretions. This would then make this lung likely to become atelectatic and infected with repeated respiratory infection, and in some, to permit the development of irreversible structural changes in the bronchi and the lung making it susceptible to infection.

KRIKOR SOGHIKIAN, M.D.

Oakland, California

KRIKOR SOGHIKIAN, M.D., a native of Egypt, received his medical degree from Fuad First University in Cairo in 1949. He received the M.P.H. degree from the University of California at Berkeley in 1958 and became a Diplomate of the American Board of Internal Medicine in 1961. He has been Clinical Instructor in Medicine, University of California Medical Center, San Francisco, since 1966 and Chief, Division of Preventive Medicine and Health Center, Permanente Medical Group, Oakland, since 1967. He will speak to the General Assembly as a member of the panel on "Efficiency in Medical Practice," at 10:30 A.M. on Monday, May 6. A brief summary of his remarks follows:

Medicine today faces the serious challenge of an ever-increasing demand for more and better health care. The facilities and manpower needed for this task are presently inadequate, and their development is costly and time consuming. On the other hand, the effectiveness of present day medical care can be extended by a systematic approach. Such an approach must consider the following factors:

1) organization structured on prepayment and hospital-based group practice;

2) emphasis on preventive medical care through health evaluation and health education;

3) optimum utilization of paramedical personnel; and

4) increasing dependence on automated techniques and computer usage.

Through such an integrated system, medical practice may fulfill, with the necessary efficiency, the potential of this challenge.

AMOS NEILL JOHNSON, M.D.

Garland, North Carolina

AMOS NEILL JOHNSON, M.D., received his medical degree from the University of Pennsylvania and interned at Jackson Memorial Hospital in Miami, Florida. He is a past president of the North Carolina State Medical Society, the North Carolina Chapter of the American Academy of General Practice and also of the American Academy of General Practice. He is presently Chairman of the Committee on Health Services of A.A.G.P. and North Carolina delegate to A.M.A. He is also an advisor to numerous medical, health and educational commissions.

Dr. Johnson will join Dr. Soghikian on the panel, "Efficiency in Medical Practice," during the General Assembly on Monday, May 6.

RICHARD M. BRAMBLETT

Augusta, Georgia

RICHARD M. BRAMBLETT, Staff Industrial Engineer, School of Medicine, Medical College of Georgia, will join Drs. Soghikian and Johnson on the panel, "Efficiency in Medical Practice," during the General Assembly on Monday, May 6.

Mr. Bramblett received his Bachelor's and Master's degrees in Industrial Engineering from Georgia Tech and is a candidate for the Ph.D. there. He is presently engaged in planning logistical support systems and in consulting with various curriculum planning committees regarding scheduling and resource allocation problems relative to the proposed Research and Education Building to be constructed at the Medical College of Georgia.

Mr. Bramblett is a member of the American Institute of Industrial Engineers, the American Hospital Association, and a member of the adjunct faculty of the Program in Hospital and Medical Systems of Georgia Tech and the Medical College of Georgia. As his part of the panel discussion, Mr. Bramblett will speak on "Modern Industrial Engineering—A Significant New Resource of the Health Industry." An outline of his remarks follows:

I. Some Useful Concepts and Definitions
II. The Philosophy of Industrial Engineering in the Health Industry
III. The Health Industry—The Matter of Uniqueness and the Role of Traditions
IV. Service, Educational, and Research Activities of an Organized Program of Methods Improvement
V. Some Illustrations of Current Activities
VI. The Future—A Prognosis

PAUL JONES FANNIN

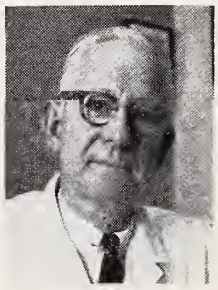
Phoenix, Arizona

PAUL JONES FANNIN, Republican Senator from Arizona, is a graduate of Stanford University. He served three terms as Governor of Arizona and was elected to the United States Senate in 1964. He is a member of the Senate Interior and Insular Affairs Committee, Senate Labor and Public Welfare Committee, Senate Post Office and Civil Service Committee, Special Subcommittee on Bi-Lingual Education, Special Subcommittee on Indian Education and Chairman, Republican Calendar Committee.

Senator Fannin will speak to the General Assembly at 11:30 A.M. on Monday, May 6. His topic will be "Politics Without Doctors Is Bad Medicine."

CURRIER McEWAN, M.D.

New York, New York



CURRIER McEWAN, M.D., received his medical degree from New York University. He completed his internship and residency on the New York University Medical Division of Bellevue Hospital, spent four years in research on rheumatic fever at the Rockefeller Institute and then returned to New York University School of Medicine where he became Dean in 1937. In 1955 Dr. McEwan resigned as Dean to devote full time to his activities as Professor of Medicine and Chairman of the Rheumatic Diseases Study Group. He is currently President of the Medical Board of Bellevue Hospital.

Dr. McEwan is past president of the New York and American Rheumatism Associations, a former member of the National Institute of Arthritis and Metabolic Diseases, an incorporator of the Arthritis Foundation and a member of its Board of Directors.

Dr. McEwan will speak before the Internal Medicine Section Meeting on Monday afternoon, May 6, on "A Rheumatologist's Evaluation of Orthopedic Measures in the Management of Arthritis." A short abstract follows:

Probably the single most important advance in the management of patients with arthritis in the past decade has been the growing awareness by rheumatologists and orthopedists alike of the value of orthopedic measures. The average physician quite naturally thinks chiefly of benefits that can be achieved with drugs. The help which medications can give is, to be sure, substantial but it must be emphasized that it is the rare case indeed that requires only this type of treatment. The overwhelming majority of patients require a comprehensive program including, as a basic minimum, therapeutic exercises and, often, splinting to prevent deformities.

The help that the orthopedic surgeon with special experience in arthritis can bring to the patient with handicapping or disabling deformities is of the greatest importance. Many who have not walked for years can be enabled to do so and even the most severely disabled patient usually can be benefitted to some degree.

A newer approach is the use of early synovectomy to prevent destruction of joints. This procedure has, of course, a proven place in most salvage operations to rehabilitate already damaged joints. Just what its role should be in the prevention of damage is not yet certain but it appears to be promising. Plans are being made for a carefully controlled clinical trial which should provide the information needed for full evaluation of it.

CHARLES F. WOOLEY, M.D.

Columbus, Ohio

CHARLES F. WOOLEY, M.D., is Associate Professor of Medicine at Ohio State University College of Medicine and Director of the Cardiac Catheterization Laboratory at the University Hospital.

Dr. Wooley received his medical degree from New York Medical College; had his postgraduate training and held a cardiac fellowship at Ohio State. He is a Diplomate of the American Board of Internal Medicine and a Fellow of the American College of Physicians.

Since 1965 he has held a Career Research Development Award from the United States Public Health Service.

Dr. Wooley will speak at 3:00 p.m. Monday, May 6, before the Internal Medicine Section Meeting. A summary of his paper, "Clinical Application of Cardiac Pacemakers," follows:
OSwCetashrdlu

1) A consideration of the multiple arrhythmias in varying clinical situations that constitute the indications for temporary venous pacemaker therapy, based on 190 clinical experiences.

2) A discussion of the therapy of symptomatic complete heart block, considering the advantages and disadvantages of epicardial versus endocardial pacemaker, based on experiences with 99 patients with long term follow-up.

ROBERT F. BRADLEY, M.D.

Boston, Massachusetts

ROBERT F. BRADLEY, M.D., received his M.D. degree from Yale University School of Medicine. He interned at Vanderbilt University Hospital in Nashville. A Diplomate of the American Board of Internal Medicine, he is currently Physician, New England Deaconess Hospital and Clinical Consultant in Medicine at Boston Lying-In Hospital and Boston City Hospital.

Dr. Bradley is a Fellow of the American College of Physicians, a member of the board of directors of the American Diabetes Association, a member of the American Federation for Clinical Research, the American Society of Internal Medicine, and a past president of the New England Diabetes Association.

Dr. Bradley will speak to the Internal Medicine Section Meeting at 3:30 P.M. on Monday, May 6, on "New Aspects of Diabetes Mellitus—Research and Treatment." A short summary follows:

Some of the most interesting recent developments in diabetes are related to the behavior of the insulin mechanism both in normal individuals and those with either so-called prediabetes or early diabetes prior to the overt stage. Various factors have been described which apparently are related to release of insulin apart from those previously known such as glucagon and those possibly arising in the duodenum.

Most emphasis will be placed upon treatment of diabetes, which will be correlated with the various stages of diabetes from the so-called prediabetic state to overt diabetes to the unstable and brittle patient. Because the latter is of such great importance clinically and is such a difficult problem for the practicing physician, the more difficult patient will be discussed in some detail.

Perhaps the greatest problem from the standpoint of morbidity in young patients with long-duration diabetes is that of diabetic retinopathy. A means of handling this problem will be discussed including pituitary ablation, photocoagulation, etc.

NATHAN A. WOMACK, M.D.

Chapel Hill, North Carolina

NATHAN A. WOMACK, M.D., Kenan Professor and Chairman Emeritus of the Department of Surgery, University of North Carolina School of Medicine, Chapel Hill, will speak before the Surgery Section Meeting, Monday, May 6, at 2:30 P.M. and again at 4:00 P.M.

Dr. Womack received his M.D. degree from Washington University in St. Louis, Missouri, and residency surgical training at Barnes Hospital in St. Louis. He taught at Washington University from 1930 to 1948, was Head of the Department of Surgery, University of Iowa School of Medicine from 1948-1951, and Head of the Department of Surgery at the University of North Carolina School of Medicine from 1951 to 1967.

Dr. Womack will speak first on the "Development of Gallstones."

> A brief background will be given of previous work done concerning the formation of gallstones. The structure of stones in the human will be considered and compared with stones formed experimentally in the animal. The development of cholecystitis and choledocholithiasis will be discussed.

Dr. Womack will speak at 4:00 P.M. on "The Nature of Splenomegaly."

> The structure of the spleen will be described as it relates to function. Various types of splenomegaly will be considered but in particular that relating to the hemodynamics of the splenic circulation. Method of diagnosis and treatment will be given.

EDGAR J. POTH, M.D.

Galveston, Texas

EDGAR J. POTH, M.D., Ashbel Smith Professor of Surgery at the University of Texas Medical Branch in Galveston, received his medical degree from the Johns Hopkins University School of Medicine.

Dr. Poth will speak to the Surgery Section Meeting, Monday, May 6, at 3:00 P.M. and again at 4:30 P.M. His first address is entitled "Physiologic Indications for Surgical Treatment of Peptic Ulcer." A short abstract follows:

> The status of peptic ulceration in the highly significant period around 1930 will be discussed.
> The newer physiology of the stomach and duodenum will be presented with a logical assessment of this knowledge as it should influence the surgical treatment of the complications of peptic ulceration and the evaluation of the position of surgical ablation of the stimulating mechanisms of gastric secretion and recently the presentation and possible augmentation of the inhibiting mechanisms.
> The presentation of some clinical applications.

At 4:30 P.M., Dr. Poth will speak on the "Controversial Aspects of Preoperative Colon Antisepsis," which is abstracted below:

> The positive effects of altering the intestinal flora in regards to the type of healing which occurs especially following surgical trauma and influence upon the microcirculation of the bowel will be presented.
> The outgrowth of resistant organisms in the gastrointestinal tract as altered by local outbreaks of staphlococci which elaborate enterotoxins and may cause enterocolitis and the control of these flare-ups.
> Presentation of clinical procedure and results.

GENERAL ASSEMBLY SPEAKER

PAUL JONES FANNIN, ***U.S. Senator from Arizona***

"Politics Without Doctors Is Bad Medicine"

Woman's Auxiliary Medical Association of Georgia

43rd Annual Meeting

PRESIDENT'S INVITATION

WHAT A PRIVILEGE it is for me as your President to welcome you to this our 43rd Annual Convention of the Woman's Auxiliary to the Medical Association of Georgia. For months I have been excited over plans being made by the Richmond County Auxiliary for this meeting. They have truly rolled out the red carpet—and I know that each of us will be glad we had a chance to walk on it. My sincere hope is that this convention will remain in our minds and hearts as one of joy, accomplishment, and closeness to one another.

Most sincerely,

Mrs. James H. Manning, President
Woman's Auxiliary to the
Medical Association of Georgia

WELCOME TO AUGUSTA

THE WOMAN'S AUXILIARY to the Richmond County Medical Society cordially welcomes you to the 43rd Annual Meeting of the Woman's Auxiliary to the Medical Association of Georgia. We hope this will be one of the best conventions ever. Please let us know if we can assist you in any way.

Sincerely,

Mrs. H. D. Scoggins, President
Woman's Auxiliary to the
Richmond County Medical Society

Rules to Govern the Convention

1. The voting body of the convention shall consist of the members of the Executive Board of the Woman's Auxiliary to the Medical Association of Georgia and the duly accredited delegates from the county auxiliaries. No one is entitled to vote until registered.
2. To gain recognition, a delegate is requested to rise, address the chair, give her name and the name of her auxiliary.
3. No delegate shall speak more than twice on the same subject, and is limited to two minutes each time.
4. Badges must be worn by members of the voting body during all general sessions of the convention.
5. Delegates' privileges are not transferable.
6. All motions shall be presented in writing to the Recording Secretary. They shall be signed by persons making and seconding the motion.
7. All original motions on resolutions shall be made by submitting two copies, one to the Resolution Committee and one to the Recording Secretary.
8. All persons appearing on the program must be seated near the platform when the session opens.

Whispering greatly retards the business of the meeting. Order must be maintained at all times. Please be prompt. Meetings will begin promptly at the time announced.

The Program

SUNDAY, MAY 5

11:00 to 5:00 Registration
Richmond Hall
Augusta Town House Motor Inn

12:00 Pre-Convention Executive Board Meeting—Dutch Luncheon (Georgian Room)
PRESIDING—Mrs. James H. Manning, Marietta, *President,* Woman's Auxiliary to MAG
INVOCATION—Mrs. A. Worth Hobby, Atlanta, *Past President*
PLEDGE OF LOYALTY AND COLLECT—Mrs. F. Morris Davis, Tifton

5:00 MAG General Business Session (Embassy Room)
(All MAG and Auxiliary Members Invited)
PRESIDING—John T. Mauldin, Atlanta, *President*

MONDAY, MAY 6

9:00 MAG General Business Session and House of Delegates Meeting (Embassy Room)
(All MAG and Auxiliary Members and Guests Invited)
PRESIDING—John T. Mauldin, Atlanta, *President*
REPORT OF WOMAN'S AUXILIARY TO MAG—Mrs. Haywood S. Phillips, Augusta, *President-Elect*

9:00 to 3:30 Registration
(Richmond Hall)

9:30 Auxiliary General Meeting (Teakwood Room)
CALL TO ORDER—Mrs. James H. Manning, Marietta, *President*
INVOCATION—Rev. Arthur O'Neal, Pastor, Aldersgate Methodist Church, Augusta
PLEDGE OF ALLEGIANCE AND COLLECT—Mrs. Fred K. Schmidt, *President,* Cobb County Auxiliary
ADDRESS OF WELCOME—Mrs. Henry Scoggins, *President,* Richmond County Auxiliary
RESPONSE TO WELCOME—Mrs. M. K. Cureton, *President,* Walker-Catoosa-Dade Auxiliary
PRESENTATION OF CONVENTION PLANS—Mrs. William A. Fuller, Augusta, *General Convention Chairman*
INTRODUCTION OF PAGES FOR THE DAY—Mrs. Stephen Mulherin, Augusta
REPORT OF ADVISORY COMMITTEE TO THE WOMAN'S AUXILIARY TO THE MAG—W. C. Mitchell, *Chairman,* Smyrna

Greetings

PRESIDENT OF MAG—John T. Mauldin, Atlanta
PRESIDENT-ELECT OF MAG—Charles R. Andrews, Canton
INTRODUCTION OF PAST PRESIDENTS AND GUESTS—Mrs. W. P. Rhyne, Albany, *Past President*
INTRODUCTION OF GUEST SPEAKER—Mrs. W. A. Wilkes, Augusta, *Tenth District Councilor*
ADDRESS—Corbett Thigpen, Augusta
INTRODUCTION OF MRS. LOUIE H. GRIFFIN—Mrs. John A. Meier, Albany, *Past President*

Business Session

(All reports limited to two minutes)
CONVENTION RULES OF ORDER—Mrs. Louie H. Griffin, Claxton, *Parliamentarian*
ROLL CALL AND MINUTES—Mrs. Neal F. Yeomans, Waycross, *Secretary*
TREASURER'S REPORT (Including Auditor's Report)—Mrs. C. James Roper, Jasper, *Treasurer*
PRESIDENT'S REPORT—Mrs. James H. Manning, Marietta, *President*
PRESIDENT-ELECT'S REPORT—Mrs. Hayward S. Phillips, Augusta, *President-Elect*
ADDENDUM REPORTS—State Officers and Chairmen (Complete reports are published in the 1967-68 Annual Report Book)
RECOMMENDATIONS FROM THE EXECUTIVE BOARD—Mrs. Neal F. Yeomans, Waycross, *Secretary*
REPORT OF THE REVISIONS COMMITTEE—Mrs. John T. Leslie, *Past President,* Avondale Estates, *Chairman*

REPORT OF THE CREDENTIALS COMMITTEE—Mrs. Julius T. Johnson, Augusta, *Chairman*

ANNOUNCEMENTS

12:00 Recess of Session

10:30 MAG General Assembly (Embassy Room)
(All MAG and Auxiliary Members and Guests Invited)

1:00 Luncheon (Georgian Room)

PRESIDING—Mrs. James H. Manning

INVOCATION—Mrs. Walter L. Curtis, College Park, *Past President*

6:30 Richmond County Medical Society Social Hour (Swimming Pool Patio)
(All MAG Members and Their Wives Welcome)

8:00 MAG President's Banquet (Embassy Room)

TUESDAY, MAY 7

9:00 MAG General Business Session and House of Delegates Second Meeting (Embassy Room)
(All MAG and Auxiliary Members Invited)

9:00 Registration and Information (Richmond Hall)

9:30 Auxiliary General Meeting (Teakwood Room)

CALL TO ORDER—Mrs. James H. Manning, Marietta, *President*

INVOCATION—Dr. Jackson Robinson, Pastor, First Baptist Church, Augusta

MEMORIAL SERVICE—Mrs. W. H. Benson, Jr., Marietta

INTRODUCTION OF PAGES FOR THE DAY—Mrs. Stephen Mulherin, Augusta

ANNOUNCEMENTS

Business Session

MINUTES—Mrs. Neal F. Yeomans, Waycross, *Secretary*

REPORT OF THE REVISIONS COMMITTEE—Mrs. John T. Leslie, Avondale Estates, *Chairman*

REPORT OF THE BUDGET AND FINANCE COMMITTEE—Mrs. Murray Lumpkin, Dalton, *Chairman*

REPORT OF THE RESOLUTIONS COMMITTEE—Mrs. Evans Nichols, Marietta

REPORT OF THE CREDENTIALS COMMITTEE—Mrs. Julius T. Johnson, Augusta

REPORT OF THE COURTESY COMMITTEE—Mrs. Donald J. McKenzie, *President,* Thomas-Brooks Auxiliary

REPORT OF THE AWARDS

COMMITTEE—

Achievement—Mrs. George W. Statham, Decatur, *Chairman*

Safety and Disaster Preparedness—Mrs. Rupert H. Bramblett, Cumming, *Chairman*

AMA-ERF—Mrs. William J. Pendergrast, Atlanta, *Chairman*

Mrs. J. Boner White Scrapbook—Mrs. Charles R. Smith, Columbus, *Third Vice President*

James N. Brawner, M.D., Trophy for General Excellence—Mrs. John A. Meier, Albany

Doctor's Day—Mrs. Cliff Moore, Rome

REPORT OF MAG CONVENTION—Mr. Edwin F. Smith, Executive Secretary, MAG

REPORT OF NOMINATING COMMITTEE—Mrs. John A. Meier, Albany, *Chairman*

ELECTION OF OFFICERS

INSTALLATION OF OFFICERS—Mrs. Ralph H. Chaney, Augusta, *Past President*

INAUGURAL ADDRESS AND ANNOUNCEMENTS OF 1968-69 STATE CHAIRMEN—Mrs. Hayward S. Phillips, Augusta, *President*

PRESENTATION OF PAST PRESIDENT'S PIN—Mrs. John A. Meier, Albany

ANNOUNCEMENTS

12:00 Adjournment

12:30 Post-Convention Executive Board Meeting (Dutch Luncheon) (Walton Room)

PRESIDING: Mrs. Hayward S. Phillips, Augusta, *President*

12:30 Past Presidents' Luncheon (Dutch) (Fenwick Room)

PRESIDING: Mrs. John A. Meier, *Past President*

WOMAN'S AUXILIARY TO THE MEDICAL ASSOCIATION OF GEORGIA 1967-1968

Officers

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For Your MAG 1968 Annual Session Hotel and Motel Reservations

APPLICATION FOR HOTEL AND MOTEL ACCOMMODATIONS

Medical Association of Georgia 114th Annual Session

May 5-7, 1968—Augusta, Georgia

A HOUSING BUREAU has been established for your convenience in making hotel and motel reservations at Augusta for the 1968 Annual Session of the Medical Association of Georgia. Comparable room rates and accommodation information are listed. *Use the Reservation Form below.* Please specify your first, second and third choice hotel or motel. All requests for reservations should give: (1) anticipated date and hour of arrival; (2) date and approximate hour of departure; (3) names and addresses of all persons who will occupy the accommodations. All reservations must be cleared through the Housing Bureau. Since all requests for rooms will be handled in chronological order, you should mail your application as early as possible to secure the accommodations you request. All reservations will be confirmed.

Augusta Town House: Broad at Albion St. (722-5541). **Single $8-12, double $12-18, $3 for extra person occupying room.** 100% Air Conditioned, Swimming Pool, TV-Radio, Free inside parking, Barber and Beauty Shop, Two Cocktail Lounges, Two Restaurants, Newsstand, Gift Shop, Package Shop—Heart of Augusta—300 Rooms.
Towers: Single $14, double $16.

Downtowner Motor Inn: Reynolds at 8th St. (722-5361). **Single $9, double $12, twin beds $14.** 100% Air Conditioned, Radio-TV, Free parking. Swimming pool, Cocktail Lounge, Restaurant—100 rooms.

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University Motel: 1410 Gwinett St. (724-8204). **Single $7, double $9, 2 double beds $12.** Air Conditioned—TV, Free parking, Restaurant near-by, Adjacent Talmadge Memorial and University Hospitals—68 Rooms.

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Confirmation of your request for accommodations will be in accordance with preference indicated, if possible; if not, best substitutes will be made. Deposit of one day's room rent will be required with each request for accommodations.

Cut out and send to:

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1st Choice ..... ☐ Double Room at $ ..... to $ .....

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.....	.....
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If hotels or motels of your choice are unable to accept your reservations, the Housing Bureau will make reservations to fit your specifications elsewhere.

Maternal and Infant Care in 1967: Goals—Progress—Problems

PHILIP R. LEE, M.D., ***Washington, D.C.***

THIS IS A PERIOD of unprecedented progress in biomedical research. We are providing increased support for health manpower programs. We are devoting an increasing share of our treasure, our time and our talent to provide better health services for all Americans.

Although we have made great progress, we still have much to do, particularly for the health and welfare of mothers and children. We share the centuries-old tradition in which motherhood and babyhood have been consistently held in high esteem. However, one of our greatest failures in medicine relates to the services which are needed but are not provided in adequate quality or quantity for women of child-bearing age and their children.

Pride in Achievements

I would like to discuss some of these failings, and to suggest some ways in which they may be overcome. Let me emphasize at the outset that I do not, for one moment, wish to undervalue the services which we can and do perform for the women and children of this country. All of us can take pride in the safe delivery and salvage of an infant with erythroblastosis fetalis, successful motherhood for a woman thought to be barren, resuscitation of an infant born in respiratory distress, and the contraceptive protection which spares the mother the children for whom she and her husband cannot properly provide.

Every obstetrician has taken part in achievements such as these. Each knows the great reward which comes when a crisis is met and overcome, and the life of a mother or baby is saved.

But to be complacent in the light of these great gains is unthinkable; to be satisfied with doing a good job—when we are doing it for relatively few—is only foolish.

The truth is that we are failing to do this good job for thousands of American women and their babies. It should be our task to serve them as they should be served—to afford all of them the benefits of the great skills, techniques and humanitarian services which obstetricians command in this country today.

Let us attempt to determine just how thinly our talents are spread in terms of need. I know that this has been done in Georgia, as part of the broad study of the needs of the mentally retarded. The Georgia findings could be duplicated in many other states.

In 1965, the national infant mortality rate was 24.7 per 1,000 live births, only five per cent below the rate in 1960, when it was 26. The range among states was considerable, the highest rate, 39.4 in Mississippi, being twice the lowest, 19.8 in Massachusetts. In your own state of Georgia it was 29.2, and if the mother was Negro, 42.6.

Rate High in Larger Cities

Cities of 500,000 or more had infant mortality rates well above the national rate, as did most rural areas. In a recent study of 40 cities we found the infant mortality ranging from 42.0 per 1,000 live births in Charleston, South Carolina, to 12 in Iowa City, Iowa. See Table I.

In the 21 largest cities, only three showed significant reductions in infant mortality in 1964 as compared with 1960-62. This was a reflection of the strain on the health services due to the rising proportion of low-income families in the cities. It is the low-income families that have the most babies,

Delivered at Annual Meeting, Georgia State Obstetrical and Gynecological Society, Medical College of Georgia, Augusta, Georgia, September 29, 1967.

Dr. Lee is Assistant Secretary for Health and Scientific Affairs, Department of Health, Education and Welfare.

often more frequently and in larger number than they wish, with high rates of prematurity and the greatest frequency of complications. The positive correlation of infant mortality rate and income has been known for a long time. A recent study in New York City has demonstrated an infant mortality rate of 41.8 in central Harlem, which is low income, with a rate in the middle-income area of Forest Hills of 13.8. See Table II.

Poverty Raises Rate

High infant mortality rates are associated with poverty, limited education of the mothers, illegitimacy, prematurity, previous maternal history of stillbirth or premature delivery, short interval between pregnancies, and inadequate prenatal and interpregnancy care. To report these things is to report the obvious, but they bear repeating because the specialists in obstetrics and gynecology in this country, more than any other professional group, must provide the answers to overcome these obstacles. It isn't somebody else's job. Obviously, no group, whether professional or governmental, can do it alone. But none have more to offer than physicians whose lives are devoted to the care of women.

TABLE I

INFANT MORTALITY RATE, 1964 IN SELECTED CITIES*

County, State	Central City	Infant Mortality Rate
Charleston, S.C.	Charleston	42.0
Hinds-Rankin, Miss.	Jackson	35.4
District of Columbia	Washington	34.0
—	Richmond	31.4
Philadelphia, Pa.	Philadelphia	30.9
Orleans, La.	New Orleans	30.4
Cook, Ill.	Chicago	30.0
Fulton, Ga.	Atlanta	30.0
Durham, N.C.	Durham	29.9
—	Baltimore	29.7
Wyandotte, Kans.	Kansas City	29.0
Cuyahoga, Ohio	Cleveland	28.9
Dallas, Texas	Dallas	28.4
Wayne, Mich.	Detroit	28.0
Allegheny, Pa.	Pittsburgh	27.9
Pulaski, Ark.	Little Rock	27.2
Erie, N.Y.	Buffalo	26.9
(5 Counties)	New York City	26.9
Denver, Colo.	Denver	26.8
Richmond, Ga.	Augusta	26.6
Marion, Ind.	Indianapolis	26.4
Dade, Fla.	Miami	26.3
Multnomah, Ore.	Portland	25.4
Oklahoma, Okla.	Oklahoma City	25.0
Monroe, N.Y.	Rochester	24.9
King, Wash.	Seattle	24.8
Douglas, Neb.	Omaha	24.7
Los Angeles, Calif.	Los Angeles	24.7
Fayette, Ky.	Lexington	24.6
East Baton Rouge, La.	Baton Rouge	24.0
Chittendon, Vt.	Burlington	22.9
Alachua, Fla.	Gainesville	22.2
New Haven, Conn.	New Haven	22.1
Suffolk, Mass.	Boston	21.7
Salt Lake, Utah	Salt Lake City	21.7
Onondaga, N.Y.	Syracuse	20.9
San Francisco, Calif.	San Francisco	20.9
Santa Clara, Calif.	San Jose	17.5
Dane, Wisc.	Madison	15.6
Johnson, Iowa	Iowa City	12.0

* National Center for Health Statistics, U. S. Public Health Service.

TABLE II

COMPARISON OF POPULATION, BIRTHRATE, PREMATURITY, PRENATAL CARE, DEATH RATE, INFANT MORTALITY BY HEALTH CENTER DISTRICT, NEW YORK CITY, 1964*

Health District	Population	Birthrate	Pre-maturity	Late or No Prenatal Care	Infant Mortality
Manhattan					
Central Harlem	227,000	23.7	17.3	40.7	41.8
Kips Bay	217,000	11.3	8.4	12.3	24.6
Bronx					
Morrisania	258,000	26.8	12.7	39.6	37.3
Westchester ...	270,000	17.9	7.7	15.2	18.2
Brooklyn					
Bedford	281,000	27.2	15.2	45.8	41.9
Bay Ridge	283,000	18.3	7.0	8.4	19.1
Queens					
Jamaica East ..	305,000	20.7	10.6	23.8	28.0
Maspeth-Forest Hills .	293,000	16.1	6.4	8.5	13.8

* Bulletin, New York Academy of Medicine, Vol. 43, No. 3, March 1967.

In 1966, the most significant decrease in infant mortality in 15 years occurred with the decline from 24.7 in 1965 to 23.4 (provisional). This was a five per cent reduction in one year, instead of five years. The provisional rate for the six months ending June 30, 1967, was 22.9, as compared with 24.0 for the same period in 1966.

Large Cities Reversing Trend

Large cities are now experiencing a reversal of the previous trend toward higher rates. Dramatic declines have been registered in groups receiving comprehensive maternity care through the maternal and infant care projects supported by the Children's Bureau. Through these projects and the Federal-State maternal and child health programs, maternity care of high quality was provided to almost 400,000 women in 1966. This is almost 40 per cent of the births for women in the poverty group. About 250,000 of these women received family planning services.

In a recent report,[1] Arthur Campbell of the National Center for Health Statistics has provided a wealth of information on the need and availability of family planning services for women of childbear-

ing age. It has been evident to many, and well documented in recent studies, that poor couples of reproductive age do not control their fertility to their own satisfaction. Family planning programs available to poor people represent efforts by society to help these individuals achieve their own goals in terms of family size and the spacing of their children.

The present high fertility among the poor imposes a special burden on these families. It is estimated that the number of births per 1,000 women 15-44 years of age for the poor and non-poor are 164 and 95, respectively. In Campbell's study he found that in March 1966 there were 130 children under 18 years of age for every 100 adults of working age (18-64) living in families classified as poor. The corresponding figure among the non-poor was 62. This means that poor adults of working age have to provide for more than twice the number of children, on the average, as do adults with adequate incomes.

Based on the expressed desire of poor couples and their actual fertility patterns, it appears that the excess fertility among the poor is 36 per cent of the observed rate, or 434,000 births annually. This evidence is consistent with other observations.

Illegitimacy Is Also Problem

Another serious related problem is illegitimacy. The number of illegitimate births in this country has risen steadily for the past 25 years. In 1940 there were 90,000 illegitimate births, while in 1965 it is estimated that there were more than 290,000. The rise is particularly striking for women under 20 years of age. In the study previously mentioned, Campbell noted:

"The girl who has an illegitimate child at the age of 16 suddenly has 90 per cent of her life's script written for her. She will probably drop out of school; even if someone else in her family helps to take care of her baby, she will probably not be able to find a steady job that pays enough to provide for herself and her child; she may be impelled to marry someone she might not otherwise have chosen. Her life choices are few, and most of them are bad."

Unfortunately, this is not a rare event in our society. It is estimated that if current trends continue, during 1970 approximately 70,000 girls under 18 years of age will have a child born out of wedlock.

If these girls follow current patterns, they will give birth to 238,000 children in a five-year period. These figures are based on the New Haven Study by Sarrel.[2] In a five-year period 100 girls under 17 with one out-of-wedlock pregnancy had 240 more babies and 9 abortions. Only five girls did not become pregnant again in this period, and of those who married, only nine of the total of 100 were still living with their husbands. Sixty of the 100 girls and their children are now being supported by welfare.

Program Must Be Extended

A program focused on young unmarried mothers must be widely extended if we are to interrupt the cycle of failure to continue education, dependence on welfare, absence of normal family life and continued reproduction of illegitimate offspring.

School-age pregnant girls are readily identified through either the health or educational facilities in the community.

To reduce recidivism these girls require a comprehensive program including health, educational, and social services.

These services have little effect upon recidivism if they are fragmented. All studies support this conclusion.

There are now 36 new projects related to school-aged pregnant girls supported by the Department of Health, Education, and Welfare. Dramatic results can be achieved in programs that offer medical, social, educational, vocational and related services. In the Sarrel Study only one girl out of 50 became pregnant within a year following the institution of a comprehensive program. In a group not receiving such services almost 60 per cent were again pregnant.

Third of Babies Are Born to Poor

The problem of providing adequate services for these young women and their children is a formidable one. There are an estimated 36 million women of child-bearing age (15-44) in the United States. The majority, in my opinion, receive very adequate to excellent care. This is not the case for many of the poor and the near-poor. They number more than eight million. Of the total of over four million babies born every year, almost one third (1.3 million) are born of poor or near-poor mothers. As many studies have demonstrated, many of these women—in some areas more than 40 per cent—receive little or no prenatal care.

There are an estimated 4.6 million women among the poor and the near-poor who need contraception. Many of these women are able to exercise satisfactory control over their own fertility; many are not. For this latter group family planning services need to be made available.

Family Planning Is Beneficial

Family planning services, when made available to those who wish them and need them, can have many benefits. Not only is maternal health improved

and each child a wanted child, but infant mortality can be significantly reduced and total economic benefits exceed the costs by many times. Campbell has estimated that effective fertility control would eventually benefit over 40 per cent of the population living in poverty. Although there is great need for adequate fertility control for all those who wish it, family planning is not a panacea for poverty. The antipoverty programs supported by the Office of Economic Opportunity, as well as the many programs in health, rehabilitation, public assistance, social security, education and social services supported by the Department of Health, Education, and Welfare, are evidence of the complexity and the difficulty of many of these problems.

Great progress has been made in the past six years; however, much more can and must be done. The medical profession has a key role to play in this effort, and it begins with the care of infants and women in the child-bearing age.

Six Thousand Obstetricians Needed

How can we do the job that must be done when faced with health manpower shortages in almost every professional and technical field? In numbers alone we are sorely deficient. Some estimates indicate that we should have 20,000 obstetricians to care for the 4 million women who deliver babies every year. We have only 14,000, and the supply seems to be falling even farther behind the demand.

We have far too few nurses for the delivery room and nursery. The shortages in the allied fields are comparable, in laboratory technologists, x-ray technologists, public health nursing, family planning clinics and in many other areas.

Many programs now are in progress for the training of needed personnel and for the development of new personnel roles in health and medical services. They deserve the most earnest appraisal.

Physician Assistants Offer Hope

One of the most provocative of the new ideas is that of the physician assistant—a role which a decade or two ago most of us would have dismissed as impractical, inefficient and very likely unethical. Today it is growing in stature and offers substantial hope for the strengthening of the total health force.

Let me ask you to examine your own professional schedules. Certainly, all of you know better than I how much time you devote to work which is not truly professional. You may find it enlightening to determine how relatively few hours you spend in the examination, delivery or operating room—and how many you spend at tasks that might well be delegated to a properly qualified nurse or nurse-midwife.

There are a number of highly skilled professional responsibilities that cannot, or should not, be delegated. The midwife or physician assistant cannot, and never will, perform the Caesarean section which saves not only the baby but the mother—a procedure which can be done only by the fully-qualified obstetrical surgeon. But on the other hand, the assistant can, indeed, fill out forms, answer routine inquiries, and provide competent counsel and prenatal care, under a physician's supervision, to many a pregnant woman. This fact has been repeatedly demonstrated here and abroad.

Assistant Could Be Great Help

Such a role, provided it is properly tested and organized, can be of immeasurable help to the busy and over-burdened physician. How often have you wished to have enough time to provide first-class care for many more than you can serve now? How often have you wished to attend a seminar, or to read a journal in order to keep up with the scientific advances which can make you even more effective than now?

Quite frankly, I do not know whether the physician assistant or the nurse-midwife can provide you with this necessary extra time, and permit you to concentrate your own efforts on truly professional activity. I do believe, however, that this is a role which deserves and requires full and honest exploration, testing and demonstration. I believe that we must weigh its potentials if only for the reason that we need new assistance desperately and thus must examine every suggestion that offers any promise at all.

I do not argue that we should commit ourselves out of hand to major changes in the organization of medical practice, just for the sake of change. I do believe, however, that we will not be true to our trust if we reject new ideas just because they are new.

Other Specialists Investigating Role

The assistant role which I have discussed is the subject of investigation and testing in a number of programs in different parts of the country today. Pediatricians, for example, are beginning to rely on specially trained nurses in several parts of the country. Orthopedic assistants—many of them recruited from the ranks of military corpsmen—are already at work at many tasks previously dealt with by the orthopedist himself. Assistants for the general practitioner and internist are being trained, and I do not doubt for a moment that they will function effectively, in one way or another, in the American system of medical service. The role of the nurse in the coronary care unit is one of the dramatic developments in American medicine in the last five years.

In addition to developing new types of health manpower, we need to look carefully at the manner in which health services are organized, made available, and financed. To this end, the President has directed the Secretary of Health, Education, and Welfare to establish a National Center for Health Services Research and Development. It will serve as the focus for a national effort to stimulate and support experimentation as well as the development and testing of new models of the organization and delivery of health services. Such questions as the application of computers and other modern technology to the delivery of services, medical information systems, the effective and efficient use of existing resources, economic incentives, manpower utilization and a number of other problems can be studied. We are in the process of establishing the Center and providing funds to assist universities in developing multidisciplined, university-wide centers for health services research. Private industry has shown great interest. For example, the Lockheed Space and Missile Corporation and the Mayo Clinic have been engaged in a joint project in Rochester, Minnesota, which may markedly improve our ability to record and retrieve medical information. Rapid advances are being made in automated laboratory systems by other private industrial groups. The systems approach which has been so effectively used in the aero-space industry is beginning to be applied to some of our major health problems. These are but a few of the areas of opportunity that will be explored and supported by the National Center for Health Services Research and Development.

Millions of dollars are being spent on the organization of new studies for manpower development and systems improvement—by the Federal and State governments and by private agencies.

Beyond question, none of these studies, none of this research, and none of this effort will be of any value unless the interest of everyone in the medical professions can be enlisted.

No governmental agency can determine that these ideas, or these programs, are the ones which promise the best results. In the American society, the direction does not come from the top, but from the people as a whole. The people—and here I most certainly include the obstetricians and gynecologists of Georgia and your colleagues over the nation—are, in the end, the grass-roots sources of initiative, energy and imagination without which no Federal or State supported program can survive.

I can only say that your understanding and effort are indispensable—indeed, imperative. I can only ask you to direct your attention to the thousands of women and children who suffer because they do not have the care which we know how to give. And I can only urge you to become strong and effective partners in the common effort to correct the inequities which exist in our society today.

All of this suggests changes—and change in old habits and traditions can be painful and is often resisted. Let me suggest to you, in closing, the wry philosophy of Washington Irving, who wrote:

"There is a certain relief in change, even though it be from bad to worse; as I have found in traveling in a stagecoach, that it is often a comfort to change one's position and be bruised in a new place."

I think we can expect some bruises, and in new places. But bruises rarely cause more than transient discomfort; they can be badges of honor if they are won in a fight for a good cause.

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AMA VOLUNTEER PHYSICIANS TO MAN EYE CLINIC IN SOUTH VIET NAM THE YEAR AROUND

Sixteen months ago volunteer American physicians launched a new battle in South Viet Nam—against eye disease. At the request of the Viet Nam government, an ophthalmology program was started at Vinh Long Provincial Hospital in the Delta south of Saigon.

The first volunteer was W. Conrad Stone, M.D., Roanoke, Va., who started organizing the program in October 1966. The need for major eye treatment had been underscored by a U.S. military medical team that discovered extensive eye disease in the Delta.

More volunteers are essential to keep the program advancing towards the long-range goal of a full-fledged eye center for South Viet Nam. Charles H. Moseley, M.D., director of the AMA volunteer program, said 12 ophthalmologists are needed in 1968 in order to maintain two in Viet Nam at all times.

People are seeing now who never saw before as a result of the eye program, Dr. Moseley said. Many cataracts have been removed and children who needed glasses are getting them, he added, and the Vietnamese people have enthusiastically embraced the program.

The eye program is designed to provide care, preventive medicine, an improvement in the administration of the Vinh Long Ophthalmology Service, and teaching of Vietnamese medical students.

The Viet Nam Ministry of Health has agreed to assign senior medical students to residency training at the eye clinic, which is the only one of its kind in the country.

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Intravenous Iron-Dextran (Imferon) in the Treatment of Iron Deficiency Anemia

Careful administration of Iron-Dextran in a suitable vehicle has yielded favorable results in the authors' hands.

IRON DEFICIENCY ANEMIA is a common problem in most practices but especially so in tropical areas and in new emerging nations. Oral therapy with ferrous sulfate remains the safest and most preferred treatment, though at times a parenteral mode of administration would be more desirable.

Indications for intramuscular iron therapy include inability or unwillingness of the patient to take oral medication, severe iron deficiency late in pregnancy, continuing blood loss that cannot be adquately kept up with by oral therapy, and inability to absorb oral iron. Iron absorption may be tested by giving 60 mgm ferrous sulfate by mouth and determining serum iron levels before and three hours after the dose. If absorption is good, the rise should exceed 100 micrograms per cent.

Unpleasant or adverse effects of intramuscular iron include pain at the injection site, staining of the skin, and retention of a partial bolus of iron at the injection site. Local sarcomas have been produced in animal species[1] but not in man. Allergic reactions and anaphylactic death have been reported in rare cases.[2]

Intravenous Administration

Intravenous administration of iron may be indicated in patients who have limited muscle mass for intramuscular injection, tissue bleeding after intramuscular injection, immobilization with consequent reduction in absorption because of poor lymph flow, and in those who require a large number of injections or have a low pain threshold.

In recent years considerable interest has been shown in the intravenous use of iron, particularly iron-dextran (Imferon). In 1963 Basu[3] reported his experience using "total dose Imferon infusion," calculating the total iron need and administering it as a diluted intravenous drip given slowly over a period of several hours. Marchasin and Wallerstein[4] used undiluted Imferon as a total dose injection in 1964 treating 37 patients with systemic reaction in one case. Since then various reports, primarily from England,[5-9] Scotland,[10] Australia,[11] India[12] and Africa[13] have been published with varying degrees of adverse reaction and differences of opinion as to the mode of administration as well as the diluent to employ. The usual reactions range from mild flushing of the face, pruritis and myalgia to chills, fever, dyspnea, chest pain, vomiting, acute arthralgia, local phlebitis and anaphylactic shock.

In the Polynesian population of America Samoa, iron deficiency anemia is quite common with usual etiology of parasitic infestation, blood loss from gastric or duodenal ulcer, and pregnancy. Anemic prenatal patients usually present themselves late in the last trimester. Outpatient treatment with oral iron is frequently unsuccessful because of failure of patients to take the medication. The purpose of this study was to test the Polynesian tolerance for intravenous iron-dextran, response to therapy, the most feasible mode of administration, the safest diluent to use and the incidence and nature of any adverse effects from the treatment.

Method

A series of 16 adult Samoans were selected for intravenous administration of undiluted iron-dextran and 15 for administration of the total dose in dilution with normal saline or five per cent glucose in water.

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The iron need was calculated by the following formula:

(Desired hemoglobin) − (patient's hemoglobin) × 0.255 = needed grams of iron

$$\frac{\text{mgm iron need}}{\text{50 mgm iron per cc Imferon}} = \text{total cc Imferon need.}$$

The undiluted Imferon was given in a dosage of 250 mgm per day if the patient weighed less than 150 pounds, and 500 mgm per day if greater than 150 pounds. Premedication with 20 mgm diphenhydramine was given intramuscularly 30 minutes before the iron dose. A patient was excluded if there was any history of drug allergy, asthma, or administration of oral iron within the previous two weeks. The administration site was cleaned with ether as Imferon is unstable in the presence of alcohol or detergents. The patient was told to report immediately any sensation of face flushing, itching, dyspnea or chest pain and a tray was on hand at the bedside containing epinepherine, antihistamine, hydrocortisone for intravenous injection and assorted syringes. A test dose of 0.1 cc Imferon was given intravenously and the injection proceeded after three minutes if there was no evidence of reaction. The needle was kept in place for two minutes after completion of injection, then withdrawn. The same procedure was carried out in subsequent daily injections.

The second group of patients (total dose infusion) were similarly selected. The concentration of Imferon in 1,000 cc of normal saline or five per cent glucose in water did not exceed five volumes per cent. An initial test dose was given at ten drops per minute for 15 minutes, then the drip was opened and allowed to run in over a period of four to six hours.

Results

Group 1: The 16 patients in this group ranged in ages from 15 to 64 and had hemoglobin levels from 6.3 to 9.5 grams per cent. Seven cases had anemia due to blood loss from peptic ulcer, one from hookworm infestation, one from cirrhosis of the liver and eight from late prenatal or immediate postpartum causes.

These 16 patients received a total of 44 injections of undiluted Imferon. At 48 hours the average hemoglobin rise was 1.5 grams; at five days, 2.5 grams; and at 14 days, 4.8 grams. The average peak reticulocyte response was at the seventh day. It was possible to follow these patients closely for no longer than two weeks.

A single reaction in this group occurred in a seven and a half month pregnant patient with a hemoglobin of 8.3 grams per cent. After 3.5 cc of undiluted Imferon she had acute onset of epigastric pain, flushing of head and chest, respiratory distress and violent, sustained, tetanic uterine contractions. She was given intramuscular epinepherine, intravenous antihistamine (diphenhydramine) and inhalations of oxygen. Blood pressure dropped only slightly. Heart rate accelerated from 80 to 96. Fetal heart tones rose to 190, gradually returning to 140 as the uterus relaxed. There was no delayed reaction and the patient recovered uneventfully. It was later discovered that the patient's arm had been cleansed with alcohol at the administration site.

Group 2: The 15 patients in this group had age ranges from 18 to 70 years and hemoglobin levels from 7.7 to 9.8 grams per cent. Eight patients were in the late prenatal period, two postpartum, two with menorrhagia, two with hookworm, and one with upper gastrointestinal bleeding.

The hemoglobin and reticulocyte responses showed no difference to that reported for Group 1. The first seven patients received their total dose of Imferon as an infusion in 1,000 cc five per cent glucose in water. Two patients experienced reactions of flushing of the face and pruritis. Both abated after stopping the drip and giving intramuscular epinephrine. The last eight patients received their total dose diluted in normal saline without reaction. No delayed reactions were noted in any of these patients nor were there any signs of local or distal phlebitis.

Discussion

Intravenous iron-dextran rapidly corrects iron deficiency anemia. McCurdy[14] feels that intramuscular iron is no more effective than therapy by the oral route. More recent studies show that intravenous Imferon produces a hemoglobin synthesis of 0.3 to 0.8 gram/100 ml/day.[15] No comparison of the various routes of administration was made in the present study but the fast recovery rate appears to indicate superiority of intravenous treatment.

The incidence of reactions when the infusion is diluted in glucose is too great to consider this vehicle as a diluent. No reactions occurred when Imferon was used in normal saline. No definite explanation can be forwarded for this other than a speculated formation of an unstable Imferon-glucose combination. A single systemic reaction of moderate severity occurred with undiluted Imferon though this may have been due to preparation of the administration site with alcohol. It is also of interest to note the severe tetanic contractions of the pregnant uterus that occurred in this patient. No similar reaction has been reported in the past.

It can be concluded that the calculated Imferon need in undiluted divided intravenous doses or the

total amount as a single infusion in normal saline can be used with calculated risk. An accurate assessment of risk cannot be determined on the basis of the relatively small number of patients in this series. Careful selection of patients and meticulous attention to the administration of the Imferon should greatly reduce the likelihood of reaction. It must not be construed that intravenous iron should replace conventional oral therapy with iron salts where such would suffice.

Hamstra, et al[15] report a large series of patients in which undiluted Imferon was used. They also included 100 elective surgical patients who provided their own blood for surgery by donating up to 1,000 cc weekly in the three weeks prior to surgery. 250 mgm Imferon was given for each 500 cc of blood donated. An additional foreseeable use of intravenous iron is as a substitute for transfusions in individuals who could not accept blood because of religious beliefs.

Summary

Thirty-one patients received intravenous Imferon for correction of iron deficiency anemia. Sixteen of these were administered the drug in an undiluted form and in divided doses. One experienced a systemic reaction but recovered without untoward effects. The rise in hemoglobin was rapid over a period of two weeks. No delayed reactions or evidence of local phlebitis occurred. The second group of 15 patients received their total dose of Imferon diluted in 1,000 cc saline or glucose in water. A significant degree of reactions occurred in those receiving the dosage in glucose. None experienced reactions when the Imferon was given in normal saline.

Though not without danger, discriminant use of intravenous Imferon by the methods and techniques described should find a useful place in correction of severe iron deficiency anemia.

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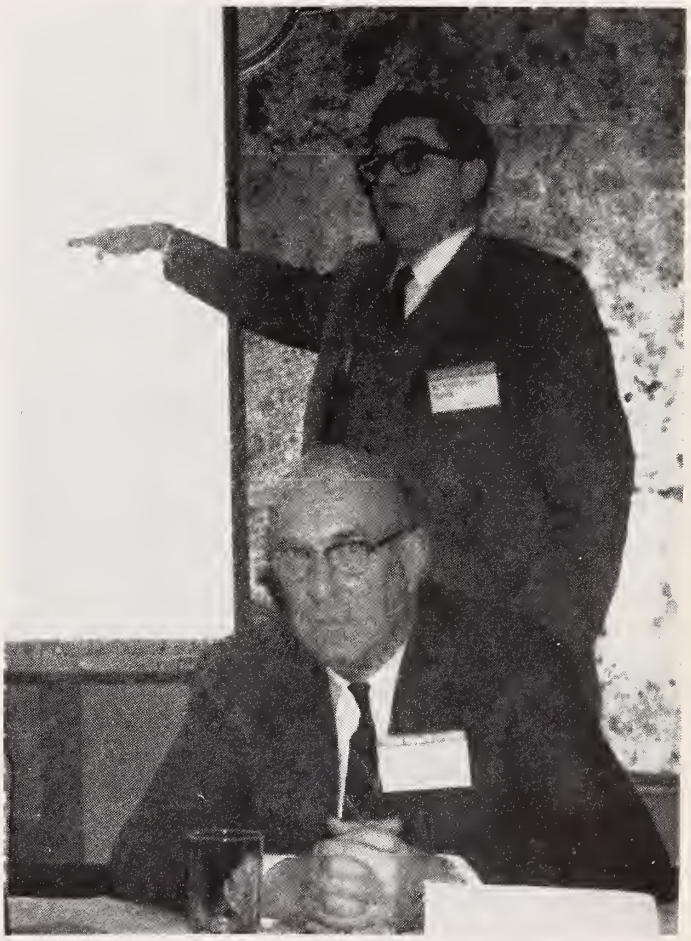
TENTH ANNUAL LEADERSHIP CONFERENCE BIG SUCCESS



More than 100 state and county medical society officers attended the 10th Annual Officers Leadership Conference held February 3-4 in Atlanta.

Many questions concerning Medicare and Medicaid were asked by county leaders and answered by members on a panel moderated by President, Dr. John T. Mauldin.

Highlighting the program was an address by Michael H. Mescon, Ph.D., of Georgia State College. Dr. Mescon gave an eye-opening presentation on private enterprise and the individual.

In the picture above, Dr. Robert Gottschalk of Savannah, chairman of the MAG Committee on Public Service, listens as Mr. Richard Crook of Chicago speaks on "When, Why and How to Hold Committee Meetings."

In thirteen patients treated, neither complications nor morbidity were encountered

Induction of Labor by Intra-Amniotic Injection of Hypertonic Solutions

IVAN A. BACKERMAN, M.D., *and* PETER HYDRICK, M.D., *East Point*

THE PROMPT TERMINATION of mid-trimester and first trimester pregnancy is occasionally indicated and necessary. During the past five years, many investigators have demonstrated the effectiveness of intra-amniotic injection of hypertonic solutions in the induction of labor when fetal salvage is not a consideration.[5-16]

Historically, a great many investigators have sought to induce labor by means of introduction of foreign materials into the uterine cavity and amniotic sac. However, morbidity and mortality were significant factors with these methods.

Various Routes of Injection

Various routes of injection were used including trans-abdominal injection, through the anterior or posterior fornix, and injections through the cervix either between the amniotic sac and the uterine wall or following artificial rupture of the membranes. Among the substances so injected were: 20 to 40 per cent solutions of formalin, soft soaps, solutions of rivanol-sulfonamide, dextrose solutions, and concentrated saline solutions.

Injection of various substances directly into the amniotic sac in order to produce labor is far from new. In 1933 Peel used hypertonic solutions of glucose and iodine complex compound (idoxylan); he abandoned the method because of a maternal death from staphylococcal septicemia in the preantibiotic era.

In South America, the Boero method of trans-abdominal injection of 40 per cent formalin into the amniotic cavity has been widely used for many years. This is a dangerous procedure because of the possibility of accidental extra-amniotic injection of formalin.[1]

The credit for using intra-amniotic injections of hypertonic (35 per cent) sodium chloride is given to Aburel in 1934.[2]

More recently Brosset in Scandinavia successfully terminated 51 out of 54 mid-trimester pregnancies by the injection of 50 per cent glucose solutions.

Bengtsson and Csapo have done extensive work both experimentally and clinically using 20 per cent sodium chloride. They studied intra-amniotic pressures, pregnanediol excretion and placental pathology, in conjunction with hypertonic saline injections.[4-5]

The theoretical considerations, and possible mechanisms of action of hypertonic solutions in inducing labor, have been extensively studied and well presented by Csapo.[16]

Clinical reports have demonstrated that hypertonic saline is a safe and reliable means of termination pregnancy.[6, 7, 11, 12, 15, 16]

We have used this procedure in thirteen patients, using hypertonic (50 per cent) glucose in two patients, and hypertonic (20 per cent) saline in eleven.

The Patients and the Methods

A group of thirteen private patients was selected. Intrauterine fetal death was present in twelve of the thirteen patients, prior to the procedure. The thirteenth patient had the procedure performed for therapeutic abortion, for psychiatric reasons. The patients were 17-37 years old, two were primigravidas, three secundigravidas, and eight were multigravidas. Parity ranged from 0-7. The gestational period varied from 14 weeks to eight months.

The reasons for induction were varied; three patients had anencephalic gestations, two patients had Rh-Isoimmunization with erythroblastosis, one patient was diabetic with an intrauterine death, one patient was schizophrenic with suicidal tendency

(therapeutic abortion), and six patients had intrauterine fetal demise with no apparent cause.

All patients were admitted to the hospital and the procedure was performed in the delivery room. The patients were instructed to empty their bladders prior to the procedure, and none of the patients was subjected to catheterization. Accidental damage to the bladder by puncture is thereby avoided. Pre-medication is not necessary; however, the occasional anxious patient may be given a barbiturate or tranquilizer.

The patient's abdomen is prepped with betadine or merthiolate. Shaving of the abdominal skin is not necessary.

Location of Injection

Local anesthesia by means of Xylocaine or Carbocaine is infiltrated locally at the injection site. The site is usually mid-way between the symphysis and the fundus. If the uterus is below the umbilicus, the site is approximately 1 cm below the fundus. The site may be paramedian or median. The median injection site is most successful for smaller uteri.

Originally a four-inch spinal needle was used but through experience it was found that an eight-inch needle of 20 gauge was more desirable. Every effort should be made to place the needle in the amniotic sac rather than the placenta or fetus. However, traversing the placenta to reach the amniotic sac will not adversely affect the success of induction.

Aspiration of amniotic fluid is then performed. Should the operator aspirate clear or straw colored fluid the question of existing fetal death must be doubted unless this procedure is to be performed for abortion. The usual case of intrauterine fetal death is associated with a "tobacco-juice" colored amniotic aspirate.

Aspiration and withdrawal of 100-300 cc of amniotic fluid is recommended. However, this is not always possible. In certain cases of repeated bloody taps where entrance into the amniotic sac is doubted, injection should not be performed. It has been our experience that repeated bloody taps indicate that the needle is in the placenta, and since our use of the eight-inch needle we have not had this problem.

Saline Solution Preferred

At the beginning of our study we used 50 per cent glucose solution in two of the patients. Following successful reports in the literature regarding hypertonic saline, we used a 20 per cent NaCl solution for the remainder of the patients. We have

TABLE I

Case	Gestation	Fluid Withdrawn	Fluid Injected	Latency Time	Labor	Remarks
1. IUDCU*	5½ mo.	1-2 cc	125 cc G.	73 hr.	7 hr. 55 min.	In pit during last 3 hrs.
2. Diabetes	7½ mo.	180 cc	250 cc G.	100 hr.	4 hr. 20 min.	—
3. Erythroblastosis .	8 mo.	1-4 cc	200 cc S.	6 hr. 30 min.	2 hr. 8 min.	MRA 8 min. pt. del.
4. Anencephaly	6½ mo.	185 cc	200 cc S.	—	—	Failed, induced 4 days later IV pitocin MRA
5. Erythroblastosis .	7 mo.	155 cc	200 cc S.	4 hr. 45 min.	3 hr. 5 min.	—
6. Therap. abortion	14 wk.	200 cc	250 cc S.	18 hr. 40 min.	1 hr. 57 min.	—
7. Anencephaly	5 mo.	10 cc	200 cc S.	21 hr.	7 hr. 30 min.	—
8. IUDCU*	6 mo.	5 cc	250 cc S.	4 hr. 15 min.	2 hr. 12 min.	—
9. IUDCU*	6 mo.	1-4 cc	220 cc S.	9 hr.	4 hr.	—
10. IUDCU*	8 mo.	225 cc	200 cc S.	6 hr. 30 min.	5 hr. 40 min.	Previous tap was clear one week prior to this procedure
11. IUDCU*	7 mo.	2-3 cc	250 cc S.	6 hr.	6 hr. 51 min.	MRA p 5 hr. labor
12. Anencephaly	7½ mo.	1100 cc	250 cc S.	23 hr. 45 min.	1 hr. 55 min.	Hydramnios
13. IUDCU*	8 mo.	4 bloody taps	—	—	Failed induction	Later induced with IV Pitocin, needle too short

* Intra-uterine death cause undetermined.

preferred to have our saline solution prepared and sterilized within 24 hours of instillation.

It is generally recommended that a minimum of 200 cc of solution be injected for ideal results. The operator must be aware that any attempt to forcibly instill the saline under great pressure will result in possible rupture of the membranes and failed induction.

The injection site is bandaged and the patient is observed at bed rest for several hours. Following this she is permitted clear liquids and ambulation. Several patients it was noted complained of thirst following saline injection. The patient is examined by vaginal examination prior to instillation of the solution.

Results

In 11 patients the amniocentesis was successful, and the labor and delivery were totally uneventful (Table I). In all 13 patients no complications or morbidity were present. In the remaining two patients, successful induction was accomplished with intravenous pitocin and amniotomy. One of the failed inductions was due to repeated bloody taps and no saline was injected. The second case was due to our inexperience in re-injection. Patients who do not go into labor within 48 hours after injection should be re-injected.

Our experience with glucose parallels the reports in the literature, in that we were successful, but there was a longer latency period.

It is interesting to note that during this period of latency, effacement takes place without any subjective or objective signs of labor. This is mentioned, because it helps to explain the rapidity of labor once labor ensues, in spite of the fact that all of the patients had unfavorable or "unripe" cervices.

In all cases, the fetus was macerated when induction followed hypertonic solution injection. The placenta was also affected with some degree of maceration.

Latency Period Varies

The latency period (from time of instillation to beginning of labor) varied from 4 hours 15 minutes to 100 hours, with an average latency time of less than 24 hours. The majority of labors were quite short, ranging from 1 hour 55 minutes to 7 hours 55 minutes, with an average labor of 4 hours and 30 minutes.

Our results are consistent with the results reported by other investigators. We should like to emphasize the ease and facility with which this procedure may be performed in the average general hospital, as well as the advantages of this procedure to intravenous pitocin, hysterotomy, or D & C.

Summary

In 13 patients with varied reasons for induction of labor, where fetal salvage was not a consideration, we successfully induced 11 patients with hypertonic solutions. In two patients 50 per cent glucose solution was used, and in the remainder 20 per cent NaCl solution was used. We recommend the use of an eight-inch needle and re-injection within 48 hours, to avoid any future failure of induction. The average latency period was less than 24 hours, with an average labor of 4 hours 30 minutes. There were no complications and all patients had uneventful hospital stays.

We recommend this technique, using 20 per cent NaCl, as a simple and effective procedure that may be performed in any general hospital.

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1311 Cleveland Avenue

EDITORIALS

Welcome To Augusta For Annual Session

On behalf of the Richmond County Medical Society, a cordial welcome is extended you for the 114th Annual Session to be held in Augusta. It is always a pleasure to have the Medical Association of Georgia meeting in Augusta. For those members who attended the Medical College of Georgia, the meetings here in Augusta are a sort of homecoming, and for this reason we hope many of the alumni will attend. For those of you who did not attend the medical school here, we would like to extend a very special invitation.

Augusta is changing its face. Broad Street is taking on a new look. One high-rise bank and office building has been completed, another is under construction, and a third is in the planning stage. Probably the greatest change is in the medical facilities in Augusta. The area which includes the Medical College of Georgia, The Eugene Talmadge Memorial Hospital and the University Hospital has enlarged considerably, and now extends from Walton Way to Wrightsboro Road. Much new construction is under way in addition to the already existing buildings. I would like to invite you to inspect this site of major change in Augusta.

Our Local Arrangements Committee, under the leadership of Dr. Preston Ellington, has made every effort to make your visit most beneficial and enjoyable. If the society members can be of help in arranging your stay in Augusta, write: The Richmond County Medical Society, 1463 Estes Street, Augusta, Georgia 30902.

Stuart H. Prather, Jr., M.D.
President, Richmond County Medical Society

Health Careers Council of Georgia

Many health related organizations have worked sporadically in the past in recruiting health workers. It has been evident, however, that the results have not been sufficient to supply the demand for such personnel.

Competition for qualified personnel is accelerating and in order to fulfill health care demands, a greater effort is necessary to obtain people for training in the numerous health career programs.

The Medical Association of Georgia, through its Paramedical Study Committee, has established District Committees to coordinate a recruiting program. Counselors serve as chairmen of the District Committees.

Central Agency a Necessity

In view of the many groups interested and involved with "allied health personnel," it is apparent that the lack of cooperation and coordination of effort has been a handicap in effecting a solution to the problems. It was, therefore, evident that a new central and independent agency would be necessary because of the divergent groups, the broad scope of the endeavor, the overlapping of effort,

and the difficulty of a single organization of the health agencies to receive significant support from all groups.

Recently, at a meeting which included the major private and governmental groups interested in health care personnel, it was recommended that a non-profit, independent and incorporated agency be established. A steering committee was appointed with the writer serving as chairman and Mr. Arthur Arseneault of the Georgia Science and Technology Commission as secretary. This committee is composed of representatives from the Georgia Science and Technology Commission, the Board of Regents of the University System of Georgia, the Department of Public Health, the State Scholarship Commission, the Georgia Hospital Association, the Georgia Educational Improvement Council, the Joint Council on Paramedical Education, the Georgia Regional Medical Program, the Medical Association of Georgia and the Allied Medical Career Clubs.

Organizational Structure Studied

At a meeting of the Steering Committee the designation of Health Careers Council of Georgia was selected. Five subcommittees were appointed to work out the organizational structure, the recommendations of which will be considered at a meeting in the near future.

The purpose of the organization is to stimulate interest in health careers and to provide services that will facilitate the entry of qualified persons into health careers in Georgia. It is expected that this organization initially will have an executive director, an assistant director, a field representative and two secretaries. Financial support will be solicited from all available sources and hopefully by annual contributions from the major health organizations concerned.

Recruitment to Be Expanded

It is anticipated that this organization will not obviate the efforts of other health related organizations in the field of recruitment but, hopefully, increase the number of people who are interested in the need and activity of specific career oriented organizations. The District Committees of the Medical Association of Georgia, for example, should continue and expand their activities in recruiting in the local schools. There is more than enough need for all groups to recruit in specific areas.

We are embarking on a program which we hope will be strongly supported by interested and concerned health organizations to begin to solve the great recruitment effort needed to provide the health workers demanded at the present time and needed for the future.

This council will be one of a small number throughout the country. It will give us an opportunity to demonstrate an effective cooperative venture among appropriate organizations to solve a serious problem through voluntary effort.

John T. Godwin, M.D., Chairman
265 Ivy St., N.E.
Atlanta

HARVARD PEDIATRICIAN TO SPEAK IN ATLANTA

Dr. Louis K. Diamond, Professor of Pediatrics at Harvard Medical School, will deliver the second Joseph Yampolsky Honorary Lecture on April 2, 1968, in the main auditorium of the Education Building of Georgia Baptist Hospital, Atlanta. The title of this lecture will be "Erythroblastosis Fetalis: The Beginnings and End of a Neonatal Disease." All physicians in the state of Georgia are invited to attend.

CANCER ARISING IN SCARS OF OLD BURNS

Harold S. Engler, M.D., ***Augusta***

EARLY IN THE FIRST CENTURY Celsus, a Roman physician, noted and recorded the development of cancer in burn scars. Among the subsequent reports of epidermoid carcinomas arising in scar tissue was a very clear and complete description by Jean-Nicolas Marjolin in 1828. So classic was his description, that the term "Marjolin's ulcer" has since been applied to carcinomas arising in chronic ulcers of the skin.

Of particular interest is the increased incidence of carcinoma in skin areas subjected to repeated thermal insults. The use of portable warming ovens worn under clothing led to the development of the "Kairo-burn" cancer of the Japanese and the "Kangri-burn" cancer of the natives of Kashmir. The Kang cancer of northwestern China similarly resulted from the artificial warming of beds and usually occurred in the area of the buttocks. And among our southern Negroes, who commonly rely upon exposure to open fires for warmth, a chronic thermal dermatitis (erythema ab igne) has been noted in the pretibial areas. This form of dermatitis, seen also in stokers, is known to precede epidermoid carcinoma occasionally. In each of these situations there is a common factor of repeated and prolonged exposure of the skin to heat, and it can be assumed that scar tissue was present as the result of repeated burns.

Scar Tissue Usually Extensive

The scar tissue most often associated with malignant disease is usually extensive, covering a relatively large area and most often associated with greatly delayed healing. Severe burns which are allowed to heal without grafting are most typical in this respect. Other types of wounds associated with malignant degeneration are also characteristically rich in scar tissue, usually the result of long-continued infection, as seen in chronic osteomyelitis and soft tissue drainage sites. Most characteristic of such areas is the long period prior to eventual healing if, indeed, complete closure ever occurs.

In most instances in which burn scars later develop malignancy, the original burns were allowed to heal without skin grafting and, therefore, had extensive scarring, prolonged infection, and slow healing. The imperfect nutrition of such a scar is partially responsible for the ease with which secondary ulceration occurs and persists. Its dry, thin, and delicate epithelium is easily destroyed by trauma, to which it is peculiarly susceptible because of location, fixation, and immobility. Treves and Pack state that each successive abrasion, ulceration, or fissure heals with increased difficulty, the quality of the regenerated epithelium is progressively inferior, and, finally, the persistent stimulation to the marginal epithelium for repeated growth and repair may lead to a loss of tissue restraint and eventual cancer. Such scars could and should be avoided by early and adequate skin grafting.

All chronic ulcers and chronically draining tracts should be biopsied, especially those of many years' duration and those having recently changed. Occasionally

an ulcer, apparently no different from other benign ulcers, will surprise everyone by being cancer when viewed under the microscope.

In most instances negative biopsies should be followed by complete wound excision with appropriate grafting. This routine would reveal increased numbers of malignancies and, in the benign lesions, would be good prophylaxis against subsequent development of carcinoma.

Talmadge Memorial Hospital

1968 CALENDAR OF MEETINGS

State

March 19-20—Recent Developments and Clinical Applications in Obstetrics and Gynecology, Continuing Education Course, Medical College of Georgia, Augusta, Ga.

March 23—Short Course on Procto-Sigmoidoscopy, Callaway Gardens, Pine Mountain, Ga. Sponsored by Muscogee County Medical Society and Muscogee County Unit, American Cancer Society.

March 28-30—American Society of Anesthesiologists Annual Postgraduate Course, Emory University, Atlanta.

April 14-17—Atlanta Graduate Medical Assembly, Marriott Motor Hotel, Atlanta, Ga.

April 17 or 18—Short Course on Procto-Sigmoidoscopy sponsored by Georgia Baptist Hospital Atlanta Medical Center and Georgia Division, American Cancer Society, in conjunction with Atlanta Graduate Medical Assembly. April 17 at Marriott or April 18 at Georgia Baptist Hospital.

April 18—Third District Medical Society, Muscogee County Medical Society, Ralston Hotel, Columbus, Ga. Registration 1 p.m.

April 24—Seminar on Colon-Rectal Diseases, Georgia Baptist Hospital Auditorium, Atlanta, Ga. Sponsored by Georgia Baptist Hospital, Atlanta Medical Center, Atlanta Metropolitan Units, American Cancer Society.

May 5-7, 1968—114th Annual Session of the Medical Association of Georgia, Town House, Augusta.

Regional

March 25-28—Southeastern Surgical Congress, Sheraton-Park Hotel, Washington, D.C.

National

March 18-20—American Academy of Pediatrics, Regency-Hyatt House, Atlanta, Ga.

March 20—National Conference on Suicidology (First Annual), Conrad Hilton Hotel, Chicago, Ill.

March 22-23—National Congress on the Socio-Economics of Health Care, Palmer House, Chicago, Ill.

March 24-30—American Society of Clinical Pathologists (Interim), Roosevelt Hotel, New Orleans, La.

March 28-30—American Fertility Society, San Francisco, Calif.

March 29-31—American Society of Internal Medicine, Hotel Statler, Boston, Mass.

March 30-April 3—American Society of Abdominal Surgeons, Sherman House, Chicago, Ill.

March 31-April 7—North American Clinical Dermatologic Society, Royal Orleans, New Orleans, La.

April 1-5—American College of Physicians, Sheraton-Boston Hotel, Boston, Mass.

April 4-6—National Conference on Health Education of the Public, Pick Congress Hotel, Chicago, Ill.

April 4-9—American Dermatological Association, Dorado Beach Hotel, San Juan, P.R.

April 5-6—Committee on Disaster Medical Care Regional Conference on Disaster Medical Care, Statler Hilton Inn, Durham, N.C.

April 7-11—American Radium Society, Fontainebleau Hotel, Miami Beach, Fla.

April 9-12—American Association of Anatomists, Jung Hotel, New Orleans, La.

April 10-12—Plastic Surgery Research Council, University of North Carolina, Chapel Hill, N.C.

April 11-13—American Association for Cancer Research (59th Annual), Haddon Hall, Atlantic City, N.J.

April 16-17—American Association of Planned Parenthood Physicians, Gunter Hotel, San Antonio, Tex.

April 17-20—American Association for the History of Medicine, Chase Park Plaza, St. Louis, Mo.

April 20-21—American Society for Artificial Internal Organs, Bellevue-Stratford Hotel, Philadelphia, Pa.

April 21-22—American Broncho-Esophagological Association, Hollywood Beach Hotel, Hollywood Beach, Fla.

April 21-26—American Laryngological, Rhinological and Otological Society, Hollywood Beach Hotel, Hollywood Beach, Fla.

April 22-24—American Association for Thoracic Surgery, Pittsburgh-Hilton Hotel, Pittsburgh, Pa.

April 22-25—American Orthopaedic Association, Boca Raton Club, Boca Raton, Fla.

April 22-27—American Academy of Neurology, Pick-Congress Hotel, Chicago, Ill.

April 25—American Society for Head and Neck Surgery, Hollywood Beach Hotel, Hollywood, Fla.

April 25-26—American Geriatrics Society, Roosevelt Hotel, New Orleans, La.

April 25-28—American Academy of Physical Medicine and Rehabilitation, Sheraton-Chicago, Chicago, Ill.

April 27-May 1—American Academy of Facial Plastic and Reconstructive Surgery, Diplomat Hotel, Hollywood Beach, Fla.

April 28-May 1—American Association of Plastic Surgeons, Shamrock-Hilton Hotel, Houston, Tex.

May 1-2—American Pediatric Society, Seaside Hotel, Atlantic City, N.J.

May 3-4—Society for Pediatric Research, Seaside Hotel, Atlantic City, N.J.

May 13-16—American Urological Association, Fontainebleau Hotel, Miami Beach, Fla.

May 19-22—National Tuberculosis Association, Rice Hotel, Houston, Texas.

May 19-23—American Thoracic Society, Rice Hotel, Houston, Texas.

May 27-29—American Ophthalmological Society, Homestead, Hot Springs, Va.

June 13-17—American College of Chest Physicians, Hilton Hotel, San Francisco, Calif.

June 15-16—American Diabetes Association, Sheraton Plaza, San Francisco, Calif.

June 16-20—American Medical Association Annual Meeting, San Francisco, Calif.

June 16-20—American College of Preventive Medicine, San Francisco, Calif.

June 18-19—American Medical Women's Association, Waldorf Astoria Hotel, New York, N.Y.

June 30-July 3—International Congress of Primatology, Biltmore Hotel, Atlanta, Ga.

ANTICOAGULATION FOR THE PATIENTS WITH CARDIAC VALVE PROSTHESES

THOMAS J. YEH, M.D., *Savannah*

SEVERAL HUNDRED PATIENTS with cardiac valve prostheses are currently living in Georgia. They are being seen by private practitioners and in the clinics in an increasingly large number. Systemic embolization is a constant hazard for these patients. In some series followed for more than a few years, as many as 25 to 60 per cent of the patients with mitral valve prostheses had systemic embolization. For the aortic valve prostheses the incidence is somewhat lower. Although improvements in the design of the prosthetic valves have been made continuously, none of the existing models is completely free from the occurrence of embolization.

Time of Occurrence Varies

Embolism has occurred as early as three days and as late as three years following the insertion of prostheses. The majority of the cases of embolization are not associated with bacterial endocarditis involving the valve prostheses, but in occasional cases the embolization is the direct result of infection. If embolization is accompanied by fever, anemia, or other signs suggesting infection, a series of blood cultures should be obtained because of the possibility of bacterial endocarditis. Cultures should, of course, be obtained prior to starting antibiotic therapy.

Most of the emboli lodge in the cerebral circulation. Symptoms are characterized by sudden onset of unconsciousness, accompanied by aphasia, monoplegia or hemiplegia. Extremities are involved occasionally and coronary arteries rarely. The embolizing particles are small, and major vessels are seldom occluded. About half of the patients recover almost completely following embolization. Very few cases are fatal.

Management of Anticoagulation

In an attempt to prevent embolization Coumadin is started on the fourth postoperative day with a loading dose of 25 mg. Subsequent dosage is adjusted to maintain prothrombin time at 20 to 25 seconds. By the time of discharge a patient is receiving somewhere between 2.5 mg to 10 mg of Coumadin daily. Prothrombin time is determined once a week thereafter, but the interval can usually be gradually extended to once a month. The patient is also given instruction regarding the warning signs of Coumadin toxicity such as bleeding from the nose, gum, urinary tract, gastrointestinal tract, and into the subcutaneous tissue. Should any of these signs appear, the patient should discontinue Coumadin and report to the family physician promptly. The patient should also be cautioned against the prolonged use of salicylates because these accentuate the effect of Coumadin.

Management of Coumadin Toxicity

The incidence of overdosage of Coumadin cannot be ignored. Aside from the usual pictures of bleeding an occasional patient presents with a picture of acute abdomen, intraperitoneal hemorrhage, or obstruction of the bowel. Fatal cerebral

hemorrhages have been reported. If prothrombin time is prolonged beyond 40 seconds and if this is associated with bleeding, Vitamin K preparation such as Mephyton should be administered. In the absence of bleeding, a minor degree of overdosage is treated by simply omitting Coumadin for two to three days.

Until further experience is gained with some of the newer valve prostheses and until data are collected and analyzed, anticoagulation should be routine for all patients with intra-cardiac valve prostheses with the exception of a small number of patients in whom management of anticoagulation is extremely difficult and in whom the risk of hemorrhage exceeds the risk of embolization.

Memorial Medical Center

GEORGIA HIGHWAY SLAUGHTER

Yearly Totals

1968 to date	109 Killed
1967	1,599 Killed
1966	1,605 Killed
1965	1,354 Killed
1964	1,314 Killed
1963	1,278 Killed
1962	1,106 Killed
1961	1,017 Killed

Through January 1968
109 KILLED

Same Period 1967
128 KILLED

January 1968
109 KILLED

Economic Loss

1968 to date	$ 20,710,000
1967	287,820,000
1966	288,900,000
1965	243,720,000
1964	236,520,000
1963	230,040,000
1962	199,080,000
1961	162,720,000

Blessed event?

Not entirely, when nausea and vomiting occur in early pregnancy. Emetrol offers prompt and safe relief. Local rather than systemic action provides emesis control on contact with the hyperactive G.I. tract.* In a study of 123 pregnant women, the drug produced measurable improvement in 79% of patients in controlling vomiting.[1]

*As shown by *in vitro* studies.
1. Crunden, A. B., Jr., and Davis, W. A.: Am. J. Obst. & Gynec. *65*:311 (Feb.) 1953.

Emetrol®
phosphorated carbohydrate solution
emesis control

WILLIAM H. RORER, INC.
Fort Washington, Pa.

BIRTH CONTROL PILLS FOR MINORS

Ronald L. Reid, ***Atlanta****

PEDIATRICIANS OFTEN POSE a question typified by the following situation. An unmarried teenage girl presents herself, without a parent, to the pediatrician and asks that the pediatrician prescribe birth control pills for her as a protection against pregnancy. From birth the girl had been brought to the pediatrician on a regular basis by her parents for the usual periodic care and treatment but the girl had not been seen by the pediatrician as a patient for some years.

The Questions

At least two questions immediately present themselves to the pediatrician, assuming the circumstances require some consideration of the request.

Can the girl lawfully consent to this "treatment?" Regardless of the answer to this first question, would the pediatrician be on safe ground in advising the girl's parents of this request?

Discussion

The question of whether or not the girl can lawfully consent to this "treatment" primarily depends upon whether or not she has been legally emancipated from her parents. If she has been emancipated, the physician is free to treat her as he would any adult. Generally speaking, under Georgia law a child is emancipated though still under 21 if the child is married or if the parents have surrendered their control over the child and allowed the child to live away from home and be self supporting. If the minor is not emancipated then the physician is required to seek the consent of the minor's parents or guardian for treatment despite the fact that the parents initially brought the child to the pediatrician for treatment. In other words, the consent which the parents gave at one time for the pediatrician to treat the child should not be considered as a continuing consent to a later treatment unrequested by them.

In regard to whether or not this request for a prescription should be disclosed to the girl's parents or guardian, this question is one which addresses itself more to the wise discretion of the physician than to clear cut rules of law. Certainly, if the girl is not emancipated the pediatrician would have to seek the consent of the girl's parents or guardian before giving the prescription. But if the girl will not allow the pediatrician to seek the consent of the parents there is a real question as to the duty and possible legal consequences of notifying the girl's parents even if the physician refuses to prescribe.

Obviously it is proper to release confidential information to a parent or guardian learned from the examination of a young child or to release confidential information to an adult son or daughter relating to a senile parent. The question of releasing confidential information otherwise is one which must be answered in light of all of the circumstances.

Conclusions

(1) If the girl is unemancipated the physician must have the consent of the girl's parents or guardian before he can lawfully prescribe. If the girl's parents will not give their consent or if the girl will not seek her parents' consent then the physician cannot prescribe.

(2) In any event, the physician should attempt to persuade the girl to bring her parents to the physician's office to discuss the request. If the girl will not bring her parents to discuss the request and will not give the physician permission either to seek their consent or discuss the matter with them, the physician must use his discretion in determining whether or not he will notify the parents of the request.

(3) In the usual situation the physician may lawfully disclose this request to the girl's parents and, in fact, his failure to do so could conceivably result in an action for damages by the parents if

* *Prepared at the request of The Medical Association of Georgia. Mr. Reid is a member in the firm of Alston, Miller & Gaines, General Counsel to The Medical Association of Georgia.*

the circumstances dictated that the physician notify them and he did not do so.

(4) If the physician decides to notify the parents of the request he should bear in mind what the reaction of the parents might be to this information. The dilemma now posed may indicate some additional thinking by the pediatrician as to the earlier conclusions mentioned.

Suite 1220
C & S Bank Building

85 YEARS AGO

IS TYPHOID FEVER CONTAGIOUS?

By W. H. PHILPOT, M.D., of Talbotton

In June last, I received a telegram from the wife of my son, Dr. L. K. Philpot, of Columbia, S.C., that he was very low with typhoid fever, expected to die, and my presence was desired.

I soon arrived, and found my son very nearly dead, and under the treatment of Drs. Tally and Trezvant. I can never cease to remember with feelings of gratitude, the untiring and devoted attention these brother physicians gave my son.

I remained with him some three weeks or more, in all his changes for better and worse, troubled bowels, hemorrhages, delirium, exhaustion, etc., expecting, as was anticipated by his physicians, he would certainly die.

It was decided, in consultation with Drs. Tally and Trezvant, that if I could convey him to my Georgia home, in a special car, his life might be saved. There he could be nursed by fond and affectionate sisters, and a devoted step-mother, who had loved him from a little child. No one ever had better attention (nursing and medical), the latter given him by Drs. Wells and Bardwell of my town. The fatigue in transit was very great, requiring a day and night stopping over in Augusta, at which time Dr. DeSaussure Ford kindly visited him, and advised for his benefit.

We arrived home, where he continued with troubled bowels, delirium, hemorrhages, etc., for three or four weeks, when his sisters, who nursed him, were stricken down with the same fever, then the mother, whose attention was devoted. One day, two; the next, three; and at last, all who watched on him, save myself, were confined to bed—making in all, five sisters, the mother, two aunts, house-girl and cook. A brother came from Arkansas to visit his sick brother, remaining twenty days. I would not permit him to nurse or sleep in the house. On his return to Arkansas, he was at once attacked with the fever, and remained under treatment four weeks. Thus making in all thirteen cases.

Three of my loved ones died, and at one time it seemed all would die from severe hemorrhages. My house and surroundings, I am satisfied, did not produce any cause for the *scourge*.

A Mr. McLendon with his small family lived near my residence. His lady was taken sick and remained so, better and worse, for several weeks. The house he occupied Mr. L. A. Baldwin moved into so soon as Mr. McLendon vacated, which was when his lady was able to move. A brother of Mr. Baldwin boarded with him, and occupied the room Mr. McLendon vacated—the furniture, bed, etc., remaining the same. This brother was stricken down and hovered for days between life and death. In the same house boarded a newly married couple; the wife was taken sick and removed to her father's in the country. Not very far away from this street a Mr. Murphy lived, having only a wife and two children with him, one more being absent in the country. A little boy of his was sick, and, thinking he would die, Mr. Murphy sent for his little daughter in the country. She came, sickened and died with her little brother whom she came to see.

In the same house lived a Mr. J. W. Hall, a young lawyer of our town, with his wife and babe, one and a half years old. The wife and babe were stricken down, the babe dying, and but for a fine, robust constitution, the wife would have succumbed even before her little babe, who lingered for some days and then died.

A Mr. McLendon, from Americus, came on a visit to our town, preparatory to moving. He was a brother of the one whose wife had been so very sick. He occupied the room in which his sister-in-law had been treated, and in a few days I was called to see him. Satisfied he was, from his peculiar symptoms, destined to be stricken as was the others, I advised him while he could to return to his own home in Americus. He did so, but was confined to bed with the fever for several weeks.

A minister, the Rev. Mr. Ivey, moved to Mr. Baldwin's as a boarder; his wife was taken sick with this fever and for weeks hovered between life and death.

A daughter of mine who had escaped up to that time, decided she would accompany her aunt, who came on a visit to us, to her home in an adjoining county, to remain only a few days. But very soon after their arrival at their destination, both aunt and daughter were taken sick and remained seriously so for several weeks.

There were other cases that could be reported, but it is not necessary. No cause locally was decided to exist at my own or the houses of those where the fever existed.

I do not set out with any intention of speaking of the treatment, etc., adopted, but desire, very respectfully, to call the attention of the Association to the mooted question: Is typhoid fever contagious? and ask a discussion of the same.

From Transactions of the Medical Association of Georgia, Thirty-Third Annual Session, 1882.

COMMITTEE ON AMA-ERF

THE COMMITTEE ON AMA-ERF is currently concentrating on ways and means of increasing annual contributions which go for education and research. Realizing that this must be a coordinated effort between MAG and its Auxiliary, a joint meeting of the two committees was held in late January to exchange ideas on just how to create more interest in the program in order to obtain more funds.

Two Projects Set for 1968

The joint committee came up with two projects for the year—(1) the promotion of a "Stay At Home Tea" and (2) an exhibit at the Annual Session in Augusta in May. The Tea has proved to be most successful in such states as Texas where the Medical Association or its Auxiliary sends out invitations to such a tea. The purpose is to contribute to AMA-ERF an approximate amount of what you would have spent on attending such a tea. The exhibit at the Annual Session will encourage the physician to contribute to the fund.

Annually, 45 million dollars are distributed among the medical schools in the 50 states for student loans from AMA-ERF. However, there is a need for uncommitted funds to be used for research purposes. This is where Georgia could really step out in front and lead the South, or perhaps, the Nation. The AMA is asking Georgia physicians to contribute $10,000 in uncommitted funds this year to AMA-ERF.

Every Physician Asked to Cooperate

The Committee on AMA-ERF would like to solicit the cooperation of every physician in the state to back this worthwhile project. More funds are needed in all categories of the Foundation. While it is good for physicians making contributions to earmark their checks for a specific purpose, it is suggested that they consider sending uncommitted checks this year so that they can be used for research purposes.

Help Georgia lead the way in the raising of funds this year. We need the assistance of every physician in the state.

Mrs. William J. Pendergrast
Woman's Auxiliary
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Watson, John D., Jr., M.D. Active—Muscogee	Medical Center Columbus, Georgia 31902

SOCIETIES

The Bibb County Medical Society's first meeting of the year in January was a session on religion in medicine. The Rev. Dr. Frederick Wilson of Vineland Methodist Church, Rabbi Harold Gelfman of Temple Beth Israel and Mons. Thomas Sheehan of St. Joseph's Catholic Church, all in Macon, participated in the program.

The Georgia Medical Society sponsored a two-day seminar on cancer early in February. It was conducted by four research experts from the Sloan-Kettering Cancer Center in New York.

The CSRA Blood Assurance Plan, which is sponsored by the **Richmond County Medical Society** and affiliated with area hospitals, has been officially started.

At the January meeting of the **Bulloch-Candler-Evans Medical Society,** heartiest congratulations were extended to Dr. Louie Griffin of Claxton, on his recent appointment to the Georgia Board of Public Health by Governor Lester Maddox. Dr. Griffin replaces Dr. Julian Quattlebaum, Jr., of Savannah, who resigned for personal health reasons.

PERSONALS

First District

Irving Victor of Savannah has been re-elected president of the medical staff of St. Joseph's Hospital. Other staff officers named for 1968 are **W. H. Fulmer,** chief of general practice; **William H. Lippitt,** chief of surgery; **Darnell L. Brawner,** chief of obstetrics and gynecology; **J. Reid Broderick,** chief of internal medicine and **F. D. Maner,** chief of inhalation therapy and intensive care.

Curtis H. Carter of Savannah has been appointed director of education in internal medicine at the Memorial Medical Center in Savannah.

Second District

"Man of the Year" in Grady County in 1967 was **C. Kenneth Singleton.** Dr. Singleton was selected by the county's five civic clubs and received a plaque at the Chamber of Commerce annual dinner in Cairo.

The Colquitt County Commissioners have named **A. G. Funderburke** county physician for 1968. Dr. Funderburke lives in Moultrie.

Third District

John H. Robinson, III, of Americus was recently presented a Gold Medallion Award for his outstanding work in the field of cancer from the Squibb Foundation.

Fourth District

An article in the *Thomaston Free Press* featured **Robert Leon Carter** who is retiring from practice. Dr. Carter went to Thomaston in 1920.

James L. Clements, Jr., of Newnan has received the fellowship degree of the American College of Radiology.

Fifth District

Atlanta's Woman of the Year for 1967 was **Amey Chappell,** a practicing physician there for 35 years. Dr. Chappell had earlier been named Woman of the Year in the "Professions" category.

Colon H. Wilson and **John McCoy** of Atlanta have been elected vice-president and secretary-treasurer of the Georgia Rheumatism Society.

Linton Bishop, new president of the Fulton County Medical Society, was honored at the President's Ball sponsored by the Woman's Auxiliary to the Society. **Mrs. Rives Chalmers** is president of the auxiliary, **Mrs. Crawford Long** was ball chairman and **Mrs. John T. Yauger** was in charge of the Decorations. **Dr. Yauger** is the party chairman for the Society.

Joseph L. Girardeau took part in a panel discussion entitled "The Population Explosion and How Atlanta Is Facing It" before the Woman's Auxiliary meeting February 2.

Radio station WSB and the Atlanta Federal Savings and Loan Association awarded one of their "Great Georgian" awards to **Bernard L. Shackleford,** an Atlanta surgeon for 46 years.

Luella Klein spoke to the Planned Parenthood Association of Atlanta at their third annual luncheon in January. She discussed the Maternal and Infant Care Project at Emory.

Thomas L. Tidmore, Jr., has been elected president of the Atlanta Association for Retarded Children. He succeeds **Walter C. Earle.**

Mary Z. Skorapa has been appointed medical director of Elks Aidmore Hospital in Atlanta.

Robert L. Egan and **Charles M. Silverstein,** both of Atlanta, have been awarded the fellowship degree of the American College of Radiology.

Sixth District

A. M. Phillips, Jr., of Macon has been inducted as a fellow into the American Academy of Orthopedic Surgery.

Eighth District

W. O. Inman has been elected chief of staff of the Glynn-Brunswick Memorial Hospital. **John Hobson** is the new vice chief of staff and **William Austin** is secretary.

Ninth District

Harold Long of Dahlonega and **John A. Cauble** of Canton have been elected to active membership in the American Academy of General Practice.

Tenth District

Alfred Jay Bollet of Augusta is the first president of the new Georgia Rheumatism Society. **Joseph P. Bailey,** also of Augusta, is chairman of the program committee.

DEATHS

William Whatley Battey

William Whatley Battey, 83, one of Augusta's oldest practicing physicians, died in Augusta January 12, 1968, after a few weeks of illness.

Dr. Battey graduated from the Medical College of Georgia in 1904 and later taught surgery there for 48 years. He was the first president of the staff at St. Joseph's Hospital and was president of the Richmond County Medical Society and the University Hospital staff. He was an attending physician at both University and St. Joseph's Hospitals.

Dr. Battey was a fellow of the American College of Surgeons, a member of the American Medical Association, Southern Surgical Congress, Southern Medical Association, Medical Association of Georgia and Richmond County Medical Society. He was a member of St. Mary's on the Hill Catholic Church. He was a Fourth Degree Member of the Knights of Columbus and for many years a Knight of St. Gregory, one of the highest honors the Catholic Church can bestow upon a layman. Dr. Battey also was a member of the board of directors of the Georgia Railroad Bank and Trust Company and the Rotary Club.

Survivors include four daughters, Mrs. Frank Fenlon and Mrs. John R. Wyant of Atlanta, Mrs. J. Lee Etheridge and Mrs. William Bush of Augusta; two brothers, Alfred M. Battey of Augusta and Dr. Colden R. Battey of Beaufort, South Carolina; and one sister, Miss Terence Battey of Augusta.

Francis M. Cronic

Francis M. Cronic, Macon radiologist, died January 20, 1968, at Macon Hospital.

Dr. Cronic was a native of Gwinett County. He graduated from Young Harris College and the University of Georgia and studied radiology in New Orleans. He served in the Army during World War II. He was a member of the Bibb County Medical Society and the Medical Association of Georgia.

Survivors include his wife, the former Evelyn Jones of Macon; two sons, Jason and Neal Cronic, both of Macon; his parents, Mr. and Mrs. J. A. Cronic of Gainesville; and one brother, G. A. Cronic, of Lula, Georgia.

E. Nesbert Gleaton

E. Nesbert Gleaton, 72, of Savannah, died January 17, 1968, after a long illness. Dr. Gleaton was a pediatrician who practiced up until last March.

Dr. Gleaton graduated from the Georgia Medical College and did postgraduate work in pediatrics at Harvard, New York University and Children's Hospital in Boston. He established a free clinic for babies in 1925.

Dr. Gleaton was a member of the Georgia Medical Society, Medical Association of Georgia, American Medical Association, Georgia Pediatrics Society and Savannah Society of Obstetricians and Pediatricians. He was a former president of the Georgia Medical Society. He was also a member of the Exchange Club and First Baptist Church.

Dr. Gleaton had been president of the medical staff of the former Telfair Hospital, chief of pediatrics at Memorial Medical Center and a member of the executive board, a staff member at Candler Hospital and was on the teaching staff of the nursing schools at Candler-Telfair, St. Joseph's, the now defunct Charity Hospital and Georgia Infirmary.

Survivors include his wife, Mrs. Nell Davis Gleaton; three daughters, Mrs. Robert M. Smith of Lynchburg, Virginia, Mrs. Earle C. Page of Gainesville, Florida, and Mrs. Gerald J. Kivett of Jacksonville, Florida; a son, Earl N. Gleaton of Savannah; and a brother, L. B. Gleaton of Brunswick.

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HIGHLIGHTS OF EXECUTIVE COMMITTEE OF COUNCIL MEETING FEBRUARY 4, 1968

This summary is being published so that the MAG membership may be advised in brief of the actions of the Association's Council and Executive Committee. It covers only major actions and is not intended as a detailed report. Full minutes of these meetings are available upon any member's request to the MAG Headquarters Office.

Third Party Payments under Medicaid were discussed including a review of the meeting held between representatives of the Social Security Administration, John Hancock Insurance Company, State Department of Public Health and MAG, which looked into the provisions of the contract between Emory University and Grady Memorial Hospital on distribution of funds received for patient care at Grady Hospital.

Liaison Meeting With the State Board of Medical Examiners regarding changes in the law governing practice privileges of osteopaths and provisions whereby certain osteopaths would be permitted to take the medical practice examination were reported to the Executive Committee. The several meetings which have included representatives of the State Osteopathic Association have produced acceptable steps toward licensing those Doctors of Osteopathy who are qualified to take the medical practice examinations, and establish practice limitations on those not qualified to practice medicine.

The Annual Session Committee brought their concern regarding commercial exhibits to the Executive Committee; their thought being that several of the pharmaceutical companies have expressed the desire of contributing financially to the Annual Session in lieu of an exhibit and other companies should be approached to determine their feelings regarding this practice. All the companies will be contacted by the Committee.

OTHER MATTERS CONSIDERED WERE:

—Announcement that Dr. Thomas J. Anderson of Atlanta had been elected chairman of the newly appointed Comprehensive Health Planning Council.

—Nominations for re-appointment to the Workman's Compensation Board: Dr. Alex P. Jones of Griffin and Dr. Jack Norris of Atlanta, whose terms expire March 30, 1968.

—Notice that the contract with the Department of the Army naming MAG as the Fiscal Agent for Georgia for 1968 has been signed.

—A report on progress in the development of the Health Careers Council of Georgia, an independent, privately supported organization for recruitment of health personnel, and the election of MAG member, Dr. John T. Godwin of Atlanta, as Chairman of the Steering Committee.

—A report that a request for a contribution of $300 toward a special caucus of Southeastern Delegates to the Student AMA was honored.

—Approved a survey of county medical societies by the MAG Mental Health Committee so that programs might be developed for county society meetings.

—Learned that Headquarters Building space occupied by the Woman's Auxiliary had been vacated and leased to the Georgia Regional Medical Program.

—Restated the policy of the Association that the membership addressograph plates not be used for promotion of any candidate for elective office.

SHORT COURSE ON PROCTO-SIGMOIDOSCOPY TO BE GIVEN AT CALLAWAY GARDENS MARCH 23

Invitations for the "Short Course on Procto-Sigmoidoscopy" to be co-sponsored by the Muscogee County Medical Society and the Muscogee County Unit of the American Cancer Society at Callaway Gardens on Saturday, March 23, have been extended to more than 800 physicians in a radius of 75 miles of Columbus, according to Dr. A. B. Conger, chairman of the board of directors of the Georgia Division, American Cancer Society, and chairman of the short course for both the medical society and the Muscogee County Unit of the American Cancer Society. Dr. W. D. Varner is serving as co-chairman.

Dr. Conger said, "With cancer of the colon-rectal area responsible for the deaths of 1,599 Georgians between 1964 and 1966, we are trying to bring to the attention of physicians in this area of the state the importance of the use of the 'procto' as a routine part of the yearly cancer detection examination."

"With the use of the 'procto,'" Dr. Conger added, "75 per cent of these cancers can be found and 68 per cent of them can be cured if diagnosed and treated while still localized. Only 13 per cent can be detected with a digital examination."

This short course is a part of the expanded efforts of the Professional Education Committee of the Georgia Division, American Cancer Society, to provide physicians in Georgia with the latest developments of diagnosis and treatment of cancer.

Program participants will include Dr. John P. Wilson, medical vice president of the Georgia Division, American Cancer Society, and Dr. J. D. Martin, professor and chairman, Department of Surgery, Emory University, both of whom are from Atlanta. Other participants from Columbus include Dr. S. A. Roddenberry, Dr. Harry H. Brill, chief of staff at St. Francis Hospital, and Dr. William G. Love, chief of surgical service, Medical Center. J. Arch Avary, vice president of the Trust Company of Georgia, a well known speaker on this subject to lay audiences, will deliver his talk, "Gone Are the Days" to the attending physicians and their wives at the luncheon on Saturday.

A social hour and dinner for the attending physicians and their wives is planned for Friday evening, March 22, in the Roof Garden at Callaway Gardens. Tours, bridge and other recreational activities are available for wives while the doctors attend the short course.

WAGE AND SALARY COMPARISON

Recently a study was conducted of union-oriented tradesmen. The following result was obtained:

Carpenters	$4.44 per hour	(40 hour week)
Electricians	$5.05 per hour	(40 hour week)
Plumbers	$4.94 per hour	(40 hour week)
Linotype Operators	$4.20 per hour	(36 hour, 40 minute week)
Bricklayers	$5.40 per hour	(40 hour week)

Based on this and computing on a basis of 40 hours straight time and 48 hours overtime, for which time and a half is paid, we arrive at the following annual income figures:

	40 hour week	*88 hour week*
Carpenters	$ 9,235.00	$25,858.00
Electricians	10,504.00	29,424.00
Plumbers	10,275.00	28,770.00
Linotype Operators	8,736.00	24,460.00
Bricklayers	11,232.00	31,450.00

The 88 hour week figure used is based on the average work week of the practicing physician.

From the Maryland State Medical Journal
December 1967

DISASTER CARE CONFERENCE PLANNED FOR APRIL 5 AND 6

A multi-faceted program on medical care in disaster situations will be presented in Durham, N.C., April 5-6.

The day-and-a-half conference is being planned by the Committee on Disaster Medical Care of the American Medical Association's Council on National Security in cooperation with the Medical Society of the State of North Carolina.

Among the topics to be discussed at the Duke University Medical Center are Emergency Resource Plans at the State and National Levels, Role of Medicine in Emergency Preparedness, Hurricane Beulah, and the Mt. Washington Cog Railroad Train Disaster.

Purpose of the conference is to promote and assist in the development of state and local programs of medical preparedness for disaster.

THE PHYSICIAN'S CAREER

In its new paperback volume, "The Physician's Career,"* the American Medical Association has provided a constructive contribution to the continuing socio-economic education of physicians. In its two parts, "The Practice of Medicine," and "The Physician in the Total Community," the book packs both factual information and an informative approach to current problems of community medicine. Its well-fleshed outline, while not a textbook, fulfills many of the practical needs of the physician in those procedural areas of practice usually ignored by medical school curricula.

* *"The Physician's Career—A Teaching Outline on Medical Practice and Community Relations, for Physicians and Medical Students," edited by Henry F. Howe, 90 pp., 75¢, Chicago: American Medical Association, 1967.*

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THE MONTH IN WASHINGTON

Dr. Dwight L. Wilbur, president-elect of the American Medical Association, warned that physicians will resist any effort to establish national medical standards under the Regional Medical Programs.

But he predicted that the medical profession would cooperate enthusiastically if the programs are carried out on a voluntary cooperative basis.

Dr. Wilbur spoke at the conference on Regional Medical Programs sponsored by the Department of Health, Education and Welfare.

"If RMP maintains its current emphasis on the working together of regional groups, it will fulfill its purpose of improving the quality, accessibility and availability of health care, physician and institutional performance, and consumer satisfaction.

"On the other hand, if RMP becomes an instrument for the establishment of national standards with the coercive compliance compelled by such standards, it will arouse nationwide resistance from physicians, institutions, and allied health professionals. What can be gained by cooperation and meaningful participation will surely be lost if the use of coercive power, which for the moment lies dormant in Public Law 89-239, becomes its dominant characteristic. . . .

"RMP is in a strategic position to bring about changes acceptable both to physicians and their patients that will improve performance and patient satisfaction without undermining patterns of behavior that are traditional, and, more significant, considered by the medical profession essential to the preservation of high quality care."

Obesity and Quackery

The American Medical Association told Congress that weight reduction is a leading health area for quackery.

The AMA position on weight reduction, particularly as so-called diet pills are involved, was outlined by Drs. Theodore B. Van Itallie of New York, N.Y., a member of the Council on Foods and Nutrition, and Harry C. Shirkey of Birmingham, Ala., vice chairman of the Council on Drugs in testimony before the Senate Antitrust and Monopoly Subcommittee.

The subcommittee was investigating reports that some osteopaths and physicians were making large incomes from assembly-line administration of multi-colored "diet" pills containing such drugs as barbiturates, thyroid extract, amphetamines, thiazine, diuretics, laxatives and various hormones.

Officials of Illinois and Oregon testified that such pills were involved in at least 20 deaths in their states.

"Perhaps in no other area of health and medical problems do we encounter as much food faddism and quackery," Dr. Van Itallie testified. "The obese are extremely gullible, forever willing to believe that someday a gadget, a diet, a pill, or a book will lead to the miracle of easy and painless reduction of weight. While most of the quackery originates with health hucksters who have no scientific background, training, or qualifications in the medical or nutritional fields, unfortunately a physician is occasionally involved.

"The American Medical Association has long utilized its various publications to bring to the profession and the public up-to-date information on the latest scientific advances in the area of obesity control. It frequently

focuses attention upon those irregular practitioners and faddists who prey upon the unsuspecting public. As the national voice of Medicine, we believe that it is incumbent upon us to help protect the public from those practices which have the potential of adversely affecting the public health. . . .

"A physician who assumes the responsibility for treating obesity takes on a difficult role. Few other medical disorders require the same disciplined and prolonged cooperation of the patient in their treatment. Even under the best of circumstances, the results of treatment become apparent slowly. The inherent handicaps may strain the busy physician's patients and tempt him to resort to unsound methods of treatment. He must have a clear understanding of the physiological and psychological problems of obesity in order to treat it wisely."

Health Care Costs

President Johnson said the administration would take additional steps to abate the increases in health care costs and to increase the numbers of health personnel.

In his economic message to Congress, he said:

"The supply of qualified health personnel has lagged behind the expanding demand. I will shortly propose new measures to increase this supply.

"Last year, medical care prices rose seven per cent, more than twice as fast as other prices. I shall propose new measures to slow down the spiraling cost of health care."

In his State of the Union message, the President included in a list of "absolutely intolerable" conditions which he said had existed for many years: "Hospital and medical costs are high, and they are rising." He did not amplify the brief statements in either of these two messages, leaving the details for a later health message to Congress.

Chairman Abraham A. Ribicoff (D., Conn.) said the Senate Government Operations Committee would conduct a two-year investigation into the rise in hospital and other health care costs. He said the subcommittee's study also would be concerned with the numbers of physicians and other health personnel.

Mr. Johnson said he also would propose a child health program and stricter penalties for those who traffic in LSD and other dangerous drugs. The child health program would provide poor families over the next five years with health service from prenatal care of the mother through the child's first year.

The budget for the Department of Health, Education and Welfare allotted $66 million for medical education in fiscal 1969, for the year beginning next July 1, an increase of more than $16 million.

Medicare expenditures for fiscal 1969 were estimated at $6.3 billion, compared with $5.7 billion for the current fiscal year.

Family planning programs of the federal government would be greatly expanded. The goal is to provide birth control information to one million women by quadrupling the size of the family planning services budget from $6 million to $24 million.

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February 6, 1968

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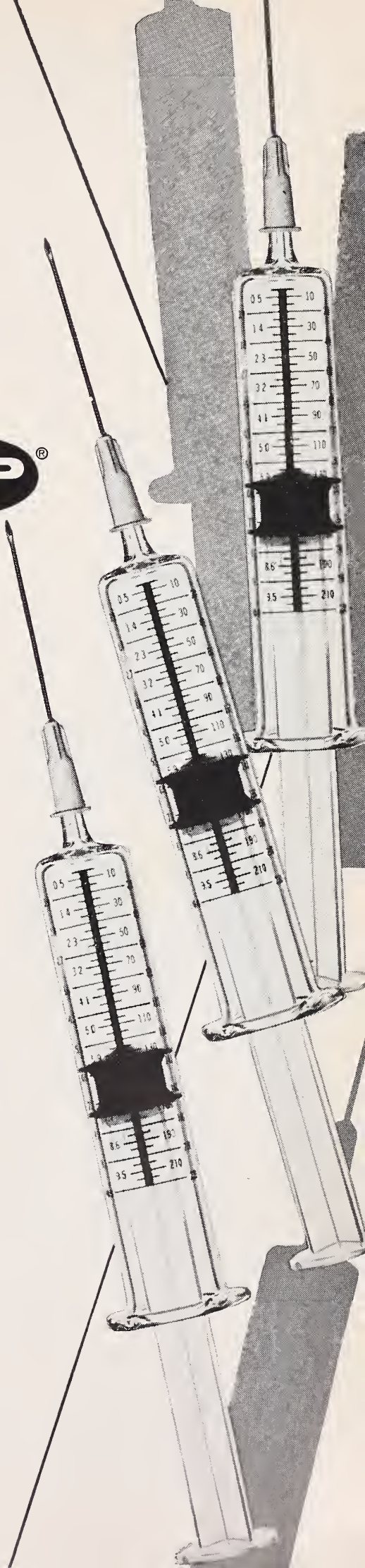

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With knowledge in this area the physician can be helpful in preventing the misuse of sex by the adolescent girl.

Misuse of Sex by the Adolescent Girl

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"SEXUAL EDUCATION" has become the designated name (or, unfortunately, at times, the misnomer) for the popular dispensing of information about the anatomy, physiology, and use of the male and female sexual apparatus to young people. Emphasis in spreading this type of information is shared by and participated in by many groups of individuals.

Medical Schools Add Courses

Medical schools recently became aware of deficiencies in training medical students in the area of sexual education when a survey disclosed that many medical students and doctors held, and thus dispensed to their patient population, false information in this vitally important area. Following an article by Dr. Lief at Tulane ("What Medical Schools Teach About Sex") several medical schools developed courses in Reproduction Physiology. Some schools developed the program through one department (Morphology or Pathology, or Endocrinology, etc.); others (George Washington University School of Medicine) developed a multidisciplinary (Psychiatry and Obstetrics, etc.) approach.

The American Medical Women's Association has as one of its points of emphasis this year the encouragement of its members to promote public health in all areas. Dr. Gertrude Ash's Committee on Social and Family Health has developed methods of reaching parents and school officials to urge improvement in sex education in the schools.

The Sex Information and Education Council of the United States, under the leadership of Dr. Mary Calderone, has developed courses to "teach the teachers," that is, to teach a core of physicians accurate sex information and ways to convey this to medical students.

Dr. William H. Masters and Mrs. Virginia Johnson have, since 1954, been involved in a Reproductive Research Project in St. Louis with the aim of investigating scientifically an heretofore unexplored area, that of the physiology of "the sexual act" (sexual intercourse). Their book, *The Human Sexual Response,* has provided new information and has dispelled myths held prior to this research.

Programs for Young People

Organizations of the lay community (churches, schools, PTA groups, YMCA, etc.) have programs for the sexual education of the young people with whom they are involved. In these groups the emphasis is wide, including health, anatomy, physiology, morals, etc., and the information is frequently given to both parents and children. Parents, who in the past deemed it their duty to educate children in these private matters, now welcome the shared responsibility of other organizations.

And lastly, mass communications media are providing much sex education. Ladies' magazines do this with awareness and intent, as a service to their lady readers. Television programs and movies, though not directly concerned with dispensing information in this area, do so in fact. Their scenes of sadistic sexuality are frequent enough to make a mark on certain young minds. And book stands in drug store, air terminal, etc., have paper back editions of numbers of books to either entertain or educate a person in matters sexual.

My Philosophy of Sexual Education

As a psychiatrist working with children and parents, I hold the idea that sexual education is a

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process, beginning with the breath of life and continuing to the end of the person's life. If learning in the early stages of the process is faulty, the foundation for further advances at later stages is weak and can thus cause sex to be misused. A healthy *experience* at each stage allows for the educational process in sexuality to continue; if a healthy experience does not occur, then formal *education* related to facts, anatomy, physiology, etc., can be assimilated and put to good use only with difficulty.

It is necessary to remember that ours is, and has been since America was settled, a predominantly Christian (or Judeo-Christian) culture. This heritage influences my philosophy (and that of the majority of Americans) to the extent that the most mature use of sex in adults is that of two adults (a male and a female) who live together, cooperate, and provide a home for the offspring which result from the sexual union. Present day religions, unlike that of our Puritanical ancestors, no longer deny that adults enjoy the sexual union and that the raising of children, when properly spaced, is fun.

The Process of Sexual Education

Sexuality begins with the infant-mother relationship. If the mother enjoys the handling of the body of the baby, if she takes pleasure in caring for the needs of the baby (hunger satisfaction, warmth, dryness, etc.), and if she does not need to unduly caress the baby when he needs no attention, or neglect him when he needs attention, and if she does not handle his body roughly, with impatience, irritation, or disgust, then the child's sexual education is off to an excellent start. The infant, as he grows, touches mother's body (breasts, if nursing; hair; mouth; eyes; etc.) as he learns to define his body limits. A good start is possible because his partner (nurturing figure) is displaying her sexuality (femininity, motherliness) in giving the care to the infant. Both partners thrive and grow in their *love experience*.

Toddler Stage

The second big stage in the process of sexual education occurs when the infant becomes a toddler, wandering away from the mother, exploring areas of new interest, and learning new definitions of his own body as he undergoes toilet training. He accepts the latter to please the mother who has become a loved figure for him. However, he now has to deal with negative feelings toward this object (the mother) who demands things from him. This is an important step forward in the process of sexual education. If the nurturing figure (the mother) is firm, kind and patient as she makes these first demands of her child for control of his bodily functions, the child will want to please the person whom he loves and will try to conform. However, if the nurturing figure is too impatient, makes too many demands, or does not respect the child's right to explore his body and his environment further, the child may become frustrated in his attempts to go forward in his development and may develop a feeling of dissatisfaction in relationship with a person whom he loves at a later time in life. Mothers, by their verbal statements and by the tone of voice and attitude used, convey to their child whether they are bothered by the child's touching himself in the genital area as all children do in the stage of toilet training. The nurturing individual who indicates by her words and attitudes that it is all right to touch any part of one's body but it is better to touch the genitals in privacy, is teaching the child that sexual feelings are enjoyed at certain times and under certain conditions.

Need to Explore Comes Next

When the child reaches the age of three to six years, his need to explore the universe outside of his relationship with his mother and his own bodily processes occurs. In this age, the child is interested in learning what other boys and girls are like, where babies come from, and even what death means. Questions asked in these areas are frank and uninhibited if the child in his previous stages of sexuality has not already been taught by mother's or parent's attitude or words that this is something which one must not notice and must avoid. When questions are asked them, parents of today usually answer in a matter-of-fact manner using words communicated through articles in ladies' magazines. Children of the age who have pets are fortunate in being able to observe procreation and the care of babies by the mother. A further area of sexual learning occurs between peers at this age; there is mutual interest in and exploration as to what other boys and girls "look like." The child handles his genitals at this age and experiences definite pleasureable feelings.

Other Interests Take Precedence

This "masturbation" is usually given up at around six years of age at which time the child's energies and attention become directed to other activities (academic learning, hobbies, skills in many areas, and further learning how to participate in groups of people). This period (6-11 years) is important to the child in areas other than sexuality. He develops increased feelings of self-confidence, self-esteem and identity as a person during this period if he has opportunities that challenge him and if he entered this age period with average maturity and mental health.

Then comes prepuberty and early adolescence. The

general public feels "now is the time to acquaint the child with sexual education." The schools frequently show films on the anatomy, physiology, disease processes, etc., connected with sexual organs of both female and male. Churches often do the same thing, going a necessary step further, in relating this to the total life plan of the individual and the particular morals which each church might be interested in perpetuating. This age period, about eleven to thirteen for girls and about fourteen to sixteen for boys, is a time of rapid growth in all physical areas and a time of tremendous changes in the sexual physiology and the sexual drive of the sexes.

Misuse of Sex in Teen-age

Now, we can spend some time talking of the misuse of sex which occurs occasionally in the period of early adolescence (11-14) and with some frequency in late adolescence (15-19) years. Dr. William H. Masters, in a talk to the Medical College of Georgia, 1967, cited an astounding statistic. "In 1965," he stated, "40 per cent of the girls who married were between fifteen and eighteen years of age; between one-third and two-thirds of these girls were already pregnant at the time of marriage." And in addition, Dr. Masters indicated that according to present trends, sociologists predict that a large percentage of these marriages will end in divorce in less than ten years. In the stage of late adolescence, the young person is faced with the task of how to handle his emergent sexuality. Masturbation, sublimation, brief homosexual experiences, intellectualization and heterosexual behavior are possible means.

Now, it is obvious that if the process of sexual education and experience were adequate during the first years of a person's life he would be free to enjoy his adult sexual feelings handling them in a responsible way. Such a person when he reaches the state of late adolescence usually wants to be married in order to carry out the next process of sexual growth which includes not only sexual intercourse but the ability to provide a home for any child which might result from the sexual act.

Intercourse Outside of Wedlock

Some people, however, decide to participate in intimate sexual relations without getting married. Many such young people take a responsible position at this time in making sure that the girl does not become pregnant by either one or both parties using contraceptive measures. Some of these people who decide to be responsible occasionally "forget" to use contraceptive measures, however, with the girl becoming pregnant.

There are other young people who have no conscious intention of producing a pregnancy, but who, through lack of knowledge or because of severe personality difficulties use no contraceptive measures. Still other girls, though unmarried, are consciously aware of wanting to become pregnant, seeking intercourse for this reason.

Resolutions of Pregnancy Out-of-Wedlock

There are several possibilities if a girl becomes pregnant out of wedlock. 1) She may get an abortion (places for this are evidently available); 2) some young people decide to marry and give the baby a name; 3) the mother, though unmarried, may give birth to the child and keep the child; and 4) the mother may stay unmarried, give birth to the child, and give the child up for adoption.

The fact that a woman becomes pregnant *out-of-wedlock,* no matter what she does about the pregnancy, may be a factor in interrupting the further growth of the usual sexual process and development of the woman; she may not be able to enjoy motherhood if her introduction to this experience was clouded by doubts of herself or her sexual partner.

As a psychiatrist, I have seen children who are products of out-of-wedlock pregnancy in which the parents solved the pregnancy in each of the above mentioned ways. My experience, of course, is a select group; there may be quite a few parents who satisfactorily resolve any unhealthy feelings about an out-of-wedlock pregnancy and, therefore, do not come to the attention of the psychiatrist.

Abortion

Of those using the first solution (abortion) one young lady, a high school student, became pregnant on more than one occasion, with the adolescent's mother taking the responsibility for the evacuation of her daughter's womb by arranging for an abortion on each occasion. It became a game in which mother and daughter were involved with the control of the inner contents of the daughter's body (just as develops at the stage of toilet training with some mothers and their children). In this case neither mother nor daughter ever considered the daughter's pregnant condition in any way connected with a baby. Sexual intercourse and pregnancy were used by the teen-ager to continue a previously unsolved conflict with the mother.

Legitimacy by Marriage

I have seen a number of children who were conceived out of wedlock but who were made legitimate by the marriage of the parents. These women tend to be always unsure that the husband really loves them, this concern itself affecting the relaxed growth of the sexual relationship between the marital partners and between mother and this child. The fathers tend to use their being "trapped" into marriage as an excuse

for their full commitment to the continued enjoyment of the relationship. Occasionally mothers continue to feel "shame" at it being known that they had relations before marriage as displayed by the "too early" birth of the first child. One rather amusing, but extremely sad, situation developed as a response to a mother's shame in this area. Her fourteen year old son, oldest of six children, was seen in psychiatric consultation with a pediatrician who was considering treatment for hastening the growth of this very small adolescent boy. After due consultation and investigation of his body image concept the boy decided to accept the treatment. At this time his mother, in almost a panic state, communicated to the therapist privately that she did not want her son to grow. She stated with embarrassment and shame that she had married when two months pregnant, that the boy was born seven months later, and she had convinced people that he was premature even though he weighed eight pounds at birth. She had tried to keep him small ever since, and was very anxious that he remain so even fourteen years later!

Mothers Who Do Not Marry

I have seen several children whose mothers, though unmarried, kept the child. The mothers subsequently married other men. Each of these children when initially seen by me showed extremely disturbed behavior; none of these children had been told any fact about their physical fathers and some were being raised as the child of the present husband of the mother, he being the professed father. These mothers were able through psychotherapy to effect more favorable handling of the child so that the child's disturbed behavior improved. However, the mother continued to fear that the child would become aware of the lie about his beginning which the mother had perpetuated.

Quite a few psychiatrists have reported their findings about those unwed pregnant women who choose to give up the baby for adoption. Studies of these girls have shown that the combination of certain conditions in a girl may cause her to be a "high risk" person for becoming pregnant out of wedlock. These are the things that have been found: 1) that such girls usually have an earlier onset of menarche; 2) that the families of such girls usually are unchurched; 3) that there is a lack of supervision in the home; 4) that such girls frequently have had unsatisfactory relationships with their parents in the past due to broken homes, disturbed marital relationships of parents, death of a parent, etc., and 5) that recently they have had a break in an important relationship either with a parent or boy friend or in another area (loss of job). These persons are noted to have a low feeling of self-esteem, to have a deep feeling of loneliness, and to see the adult world as unfriendly.

Sex Used to Solve Problems

The pregnancy for such persons somehow serves as a means of trying to reestablish a relationship with the mother or to fight the depression and loneliness existent in the young person. The misuse of sex which occurs here has to do with the fact that the sexual genital act and sexual intercourse are used in an attempt by these girls to solve problems which belong in the past. From one to two years of psychotherapeutic help with these girls is needed for them to work out the problems of the past which cause them to misuse sex in this manner, for the pregnancy does not solve the problems of the past for these girls even as it does not stimulate the girls to advance to the next area of sexuality.

The adopted adolescent girl is, in my opinion, another individual who is more prone than the general population of adolescent girls to become pregnant out of wedlock. According to Mrs. Mary Cousins, Director of Florence Crittenton Home, at Chamblee, Georgia, there is usually in the institution at any given time more than one resident (unwed pregnant adolescent) who was adopted in her early life. For these girls, the illegitimate pregnancy serves many purposes; both conscious and unconscious ("eye for an eye" philosophy; identification with the genetic "unknown" sexual mother, etc.), all of which are misuses of sex as it is destructive rather than constructive in promoting sexual maturity.

Responsibility of Physicians

With knowledge in this area the physician can be helpful in preventing the misuse of sex by the adolescent girl. Psychiatrists deal therapeutically in this area every day. Obstetricians and pediatricians also work daily with persons who are misusing sex. But no matter what field of medicine is practiced by the physician, he or she can do something very important to facilitate the process of sexual education in children long before they get to the age of mature genital sexuality when misuse of sex may occur and he can help the vulnerable adolescent girl avoid the pitfall of misuse of sex at this time. He can do this in several ways: 1) Those physicians involved in seeing mother-child interactions in the earlier stage of the child's development can encourage and support free and natural signs of love and physical affection between the mother and child; 2) by the physician's maturity in the area of talking about sexual matters he can lessen mother's anxieties in dealing with the child's investigation of and handling of his genitals when a small child; 3) he can support and participate in those organizations aimed at the children who need

to obtain self-esteem and a source of positive identity in the community (by support of Girl and Boy Scouts, Big Brothers, Big Sisters, and church groups, etc.); 4) he can encourage establishment in the community of places providing healthy excitement for teenagers because the teen-agers seek excitement and will associate with unhealthy kinds if other fun is not available; 5) he can look out for those "high risk out of wedlock pregnancy girls" and a) try to provide satisfactory life experiences for them and help them find other ways than becoming pregnant to deal with a recent experience of loss; b) he can inquire about the habits of teen-agers left at home while parents are busying themselves (work, recreation, clubs, etc.), in other places; c) he can encourage the adequate supervision of young people where needed, and d) he can give direct encouragement to young people to engage themselves in healthy group experience; 6) he can stimulate interest in volunteer groups to seek out and be available to those youngsters who have low self-esteem, feel lonely and alienated from adult society; he can consider dispensing information about and encourage the use of contraceptive devices in those people who seem, from studies done with those pregnant out of wedlock, to be high risk persons for misusing sex; 7) he can help an adopted child talk about her feelings of her unknown mother so she won't need to "act" them out; 8) physicians can share their knowledge so that layman can know, think about, discuss, and help arrive at the answers which society needs in this area; and 9) if misuses of sex by the adolescent girl occur with resultant out of wedlock pregnancy the physician can direct the parents to go to the appropriate agencies for help.

Summary

Sexual education has become popular in lay and professional groups. My philosophy of sexual education is a comprehensive one in which 1) sexual maturity is envisioned as involving a happy and successful living of parents raising children and 2) the process of achieving such maturity occurs by the education gained from the experience of the child having participated in a satisfying infant mother relationship, in a firm kindly toilet training experience, in an interesting and broadening relationship with people (adults and children) of both sexes, with a sense of responsibility in indulging in intimate sex acts as an adolescent, and with fulfillment of mature sexual interaction with a person of the opposite sex in adulthood, this recreating the family cycle, and the sexual process.

Misuse of sex by the adolescent girl can occur if she is handicapped by unsatisfactory life experience at any stage (infancy, toilet training, etc.) prior to adolescence; sexual intercourse is then used in the service of solving the frustrations of the past. Such sexual intimacy neither solves the problem of the past nor advances the sexual maturity of the individual.

The physician can and should facilitate the types of satisfying experiences a child needs in sexual education at each level of development and he should promote those activities for "high risk" teenage girls that will tend to allow them to come through adolescence without misusing sexuality; when mishaps occur he can refer the persons to appropriate agencies for help through the difficulty.

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VIEWPOINTS—CHRONIC OBSTRUCTIVE LUNG DISEASE

Medical College of Georgia, Augusta—May 4

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Marked hyperglycemia with a negative serum acetone should alert the treating physician to this condition.

Hyperosmolar Nonketotic Diabetic Coma

C. DAVID MARKLE, M.D., *and* WYMAN P. SLOAN, JR., M.D., *Atlanta*

THE CLASSIFICATION OF DIABETIC COMA has been expanded to include nonketotic comas. This includes lactic acidosis, phenformin-induced acidosis, and hyperosmolar coma.[13] Since the first description of hyperosmolar nonketotic coma in 1957,[12] there have been approximately 83 cases reported, and mortality has been placed at 44 per cent,[3] making early recognition and treatment essential. Therapy differs drastically from that used for the more common forms of diabetic coma—ketoacidosis, and hypoglycemia.

An interesting case of hyperosmolar nonketotic diabetic coma is presented, pathophysiology noted, and methods of treatment discussed.

CASE REPORT

This 33-year-old white female had a five-month history of progressing polydipsia, polyuria, polyphagia and weight loss. Her husband noted particularly that she drank large quantities of carbonated beverages.

Two days prior to admission she was noted to "sleep most of the time," and seemed to be confused when awake. The morning of admission she fell attempting to get out of bed and was brought immediately to the hospital.

No Past History of Diabetes

There was no past history of diabetes mellitus but there was a strong family history. Her maternal sister and brother and her paternal cousin had diabetes mellitus.

The physical examination revealed a blood pressure 70/0, pulse 120, temperature 105°, and respirations 26/min. The patient was hyperneic, dehydrated, irrational and hyperkinetic. The only positive physical findings were generalized abdominal tenderness and foul, purulent, vaginal discharge. There was no evidence of external injury to the head.

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Admission laboratory findings and serial changes are demonstrated in Table I.

The usual treatment of diabetic ketoacidosis was begun on admission with normal saline and insulin. The diagnosis of hyperosmolar nonketotic diabetic coma was suspected with the report of marked hyperglycemia and a negative serum acetone. Serum was saved and later checked by an osmometer to establish the diagnosis. The normal saline was immediately switched to one half normal saline. In the first 24 hours the patient received a total of 11,000 cc of fluid. See Table II.

As the hyperglycemia improved, free water was administered as five per cent dextrose in water. An attempt to give free water by intragastric tube was unsuccessful due to inability to retain the solution. See Figure 1.

During the first 16 hours of treatment the patient's hourly urine output was approximately 10 to 15 cc

TABLE I

	Admission	8 hrs.	16 hrs.	24 hrs.
Blood glucose mg%	1,470	650	238	424
Sodium ME/L	147	162	154	141
Potassium ME/L	6.2	2.3	5.3	3.5
Chloride ME/L	108	130		109
Bicarbonate ME/L	12.8	18.5		18
Blood Urea Nitrogen mg%		67		30
Serum Osmolality (milliosmols)	396	350		300
Calcium mg%	8.7			
Phosphorous mg%	0.4			
Magnesium mg%	1.4			
pH	7.26			
pCO_2	20.6			
pO_2	83			
Urine glucose	4+	2+		
acetone	4	negative		

Serum acetone—negative in undiluted specimen

TABLE II			
	1-16 hrs.	16-24 hrs.	Total 24 hrs.
Urine output	226 cc	3,191 cc	3,417 cc
Intake	2,000 cc 3,200 cc ½NS 2,000 cc D_5W	3,800 cc D_5W 60 ME KCL & 25 units Reg Insulin in first liter 15 units Reg Insulin in second liter	11,000 cc
Regular Insulin ...	240 units IV 100 units SC	57 units (15 units/liter)	437 units

per hour, with a total of 226 cc. This increased markedly to 3,191 cc in the next eight hours.

Potassium was monitored by serum, electrocardiogram, and reflexes. As in diabetic ketoacidosis, there was a marked drop during the first six to eight hours in potassium requiring intravenous administration. During the second and third days of admission the patient had to be given more potassium.

The sodium on admission was 147 ME/L and rose to 162 ME/L in 12 hours. The apparent normal sodium on admission was due to the osmotic effect of marked hyperglycemia.

The patient received a total of 437 units of regular insulin in the first 24 hours. Three hundred and sixty-five units were given in the first 12 hours with the blood glucose decreasing from 1,472 to 250 mg%.

Low Phosphorous

Ancillary laboratory findings included a normal calcium, but a low phosphorous. This was followed serially, and the phosphorous became normal after eight days. The severe osmotic diuresis probably explains the low phosphorous.[4] It is also known that hyperglycemia inhibits the phosphate tubular reabsorption.[11]

The hematological findings were interesting. The hematocrit on admission was 50 per cent, and the peripheral smear showed marked poikiocytosis with target cells, schistocytes, and crenation. Eight hours after admission the hematocrit was 33 per cent and the serum demonstrated hemolysis. This probably indicates mechanical injury to the red blood cell. The platelets were normal on peripheral smear on admission but became decreased two days after admission. This was followed with interest, although by estimate it was a very slight decrease—90,000-120,000/mm.[3] This was present only a few days, and a direct count was not done. Partial thromboplastin time, prothrombin time, and fibrinex were within normal limits.

Discussion

Sament and Schwartz first described hyperosmolar nonketotic coma in 1957.[12] There have been over 83 cases reported since that time. Recent review articles have called attention to the following: it occurs in the older age group, is never reported in juvenile diabetics, has a slight prominence in females, and occurs in patients not previously known to be diabetics.[3, 6, 13]

Marked hyperglycemia without significant bicarbonate decrease and absence of acetone in the serum should make one suspect the diagnosis of hyperosmolar nonketotic diabetic coma. Clinically it may appear very similar to diabetic ketoacidosis. Serum

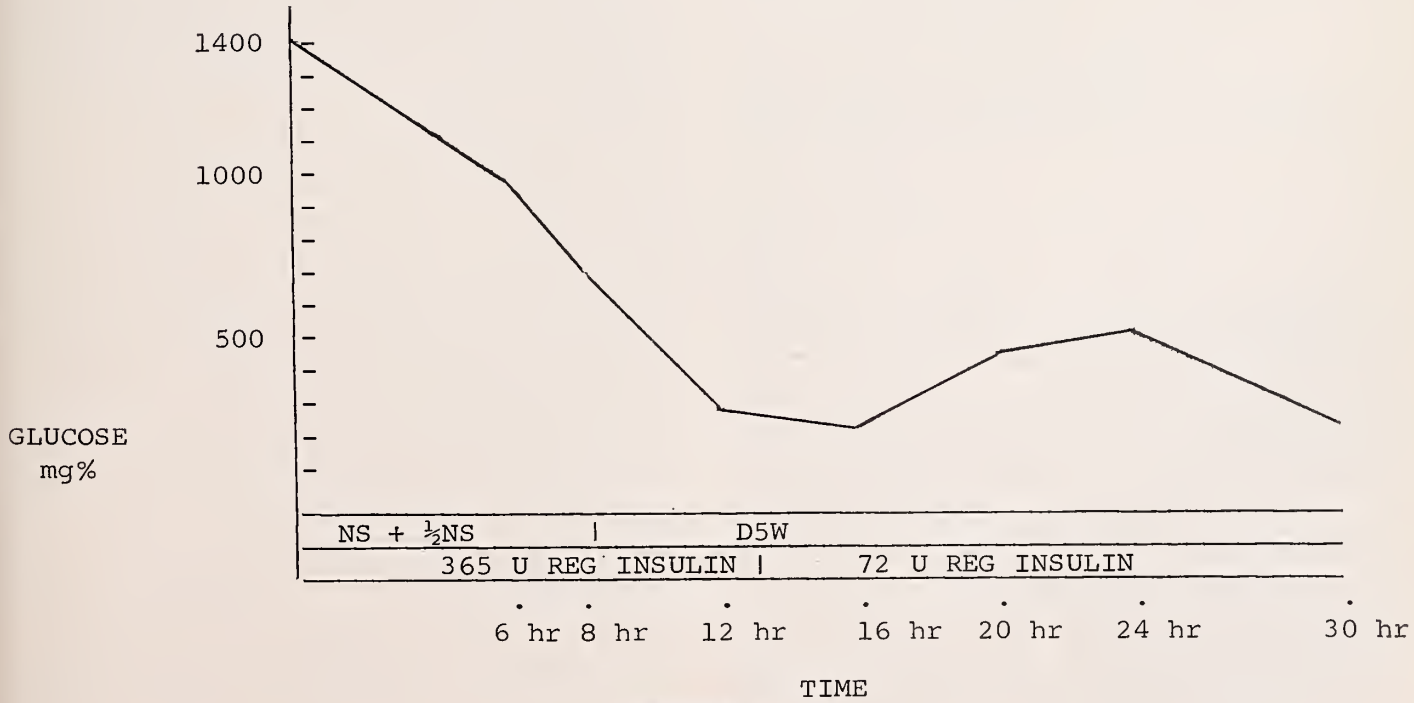

FIGURE 1

osmolality can be estimated by knowing the serum sodium and glucose concentration. This has been expressed by the formula:[13]

osmolality = 2 times Na plus glucose in Mg% /18

The serum sodium may be low, normal, or high depending on the concentration of glucose and its osmotic effect. The serum sodium alone under these circumstances may not actually reflect the extracellular hypertonicity. An estimation of the serum sodium at an equivalent osmolality can be obtained by increasing the serum sodium by 2.5 ME for every 100 mg% glucose elevation above normal. There have only been a few cases of hyperosmolar diabetic coma in which the blood glucose was normal and the serum sodium markedly elevated.[3]

"Mixed Form" Case

According to the classification of hyperosmolar coma by Danowski, the case presented is a "mixed form." The "pure syndrome" is limited to cases that have a bicarbonate over 18. A bicarbonate less than 18 is felt to represent a concurrent lactic acidosis.[2] This is consistent with the blood gases obtained in the case presented.

The coma is felt to be secondary to hypertonicity and/or hyperglycemia. The hyperglycemia causes a shift of water from intracellular space to extracellular space. An osmotic diuresis occurs and there is a greater urinary loss of water than salt.[3, 8] Neurological signs, such as both focal and generalized seizures, and post ictal signs may be prominent. The osmotic gradient may account for the seizures and the coma. The signs and symptoms may be very similar to water intoxication.[9]

Therapy Differs

The importance of recognition of hyperosmolar nonketotic coma is that therapy differs from the usual type of diabetic coma. Early recognition is essential, and normal saline, five per cent dextrose in water, sodium lactate will aggrevate the coma. The mainstay of therapy is hypotonic solutions. Large quantities, such as 11 liters in this case, are usually required in the first 24 hours. The initial one half normal saline may be switched to five per cent dextrose in water as the serum glucose decreases.[10] Free water may be administered by intragastric tube, enemas, and even intraperitoneally.[11] Hypokalemia may be prominent and potassium must be monitored with serum levels, electrocardiogram changes and reflexes.

The mortality ranges from 40 to 50 per cent. Autopsy findings include: acute pancreatitis and fatty liver,[3, 6] acute tubular necrosis,[6] cerebral infarction,[9, 14] pelvic venous thrombosis with pulmonary embolism.[13] Mortality and morbidity are related to arterial and venous thrombosis. Halmos recently reported three out of eight cases of nonketotic hyperosmolar diabetic coma that required amputation of a leg due to arterial thrombosis. Another case had venous thrombosis of the calf and thigh.[6] The slight decrease in platelets in this case was followed with interest as a possible sign of intravascular coagulation. This did not become prominent, however. The other coagulation studies were within normal limits.

Reports have indicated that these patients are sensitive to insulin due to the absence of ketoacidosis.[1, 5, 7] A recent review, however, has pointed out that these patients usually require, as our patient did, between 300 and 600 units of insulin in the first 24 hours.

Summary

A case report of hyperosmolar nonketotic diabetic coma is presented. Methods of diagnosing this serious complication are reviewed. Emphasis is placed on therapy, which differs drastically from that used in diabetic ketoacidosis.

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The intermediate and long-term usage of systemic steroids is discussed.

Systemic Corticosteroids in Dermatology

ROBERT M. FINE, M.D., *Decatur**

MOST WILL AGREE that prednisone remains the corticosteroid of choice in dermatology for a number of good reasons, not the least of which is cost. To my knowledge, no convincing evidence exists that newer analogues have any therapeutic advantages. There are reports which attribute specific properties to one steroid or another, such as triamcinolone in treating psoriasis and lichen planus, but these in general are clinical impressions which have not been substantiated by well controlled studies. It is likely that any apparent advantages are dose related and not due to drug specificity. Tablet for tablet, newer steroids appear to have more anti-inflammatory activity and, unfortunately, no one has succeeded in isolating this from their metabolic effects.

Intermittent Dosage

Recently Harter[1] noted that the therapeutic effects of steroids appeared to persist longer than their metabolic effects and this observation prompted him to study intermittent corticosteroid dosage schedules in which the daily steroid dose is doubled and administered every 48 hours. He found approximately equal therapeutic results as compared to divided daily dosage schedules but adrenal suppression and other side effects were significantly reduced. In a related study Danowski[2] found a normal response to intravenous mepyrapone in nine of ten patients after seven and a half years of large doses of corticosteroid given on an intermittent dosage schedule of three to five successive days out of each week.

It may be concluded that intermittent dosage has obvious advantages. But unfortunately not all dermatoses respond and no comprehensive studies are as yet available to indicate which ones do. Logically, more acute dermatoses requiring large steroid doses to control respond less well. Harter[1] also found that patients who were on long term steroids with resultant profound adrenal suppression could not be successfully transferred to alternate day treatment. When necessary, divided doses may be used for initial control with an intermittent regimen substituted later.

Prednisone Has Advantages

Prednisone has advantages for intermittent schedules since its suppressive effect on the pituitary-adrenal axis lasts one and a quarter to one and a half days: about one third as long as dexamethasone and betamethasone (two and three quarters to three and a quarter days respectively) and one half as long as paramethasone and triamcinolone (two and two and a quarter days respectively).[3] With the latter drugs advantages of alternate day therapy are nullified.

Since less adrenal suppression and other cortisol effects are associated with intermittent corticosteroids, it logically follows that parenteral depot and sustained release preparations such as IM triamcinolone and methylprednisolone are unphysiologic, unnecessary and undesirable; they produce a sustained plasma steroid level with continuous suppression of normal pituitary adrenal function. A recent letter from a drug company which markets an intramuscular triamcinolone preparation states that the adrenals are suppressed for about a month after an IM dose of 60 to 100 mg of triamcinolone and that this suppression is evident after 24 to 48 hours.[4] There seems to be little doubt that these IM preparations are as effective as the oral ones, but these associated effects would seem to contraindicate their use except for certain specific indications. One such is in treating the undependable patient to insure that appropriate dosages are received.

Useful in Withdrawal

Alternate day dosage is useful during withdrawal from long term steroids. The day off of medication stimulates pituitary adrenal activity, thereby promoting functional recovery without undue risk to the

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patient of acute adrenal insufficiency. In a patient who has been successfully transferred to alternate day steroids for three or four weeks further tapering off of steroids is unnecessary prior to withdrawal.[1]

Cope[5] states that adrenal recovery is rapid and complete following short term corticosteroids even with massive doses. After one or more years of therapy adrenal activity usually begins to return by 48 hours, but complete recovery may take five months or longer. During this time adrenal function is adequate for nonstressful situations. Cope[5] feels that corticotrophin will assist revival of the adrenals during withdrawal, but others, including Graber[13] and Fleischer,[14] have reported evidence which tends to make this seem unlikely.

Single Morning Dose

For patients needing daily steroids for control, a single morning dose of prednisone should be tried since this is less likely to interfere with normal diurnal adrenal secretion which peaks around 8 a.m.[6] and should be associated with fewer side effects as compared to divided doses. Grant[7] studied the effects of a single daily morning dose of 8 mg triamcinolone and found evidence of pituitary adrenal suppression as measured by a fall in urinary 17-hydroxycorticosteroid excretion. This contrasts with DiRaimondo and Forsham's[7] finding that a single morning dose of 10 mg of prednisone produced only negligible suppression of urinary 17-hydroxycorticosteroid excretion and seemed to have an additive rather than a suppressive effect. Drug manufactureres have shown an awareness of the advantages of the single dose schedule by marketing large multidose pills, but, unfortunately, jumbo prednisone tablets are not available to my knowledge.

Limited Role for ACTH

There seems to be a definite but limited role for ACTH in clinical dermatology. Friedman[8] demonstrated the advantages of corticotrophin over corticosteroids for long term treatment especially in children. Parenteral administration necessarily limits its practical usefulness and even though adrenal suppression and growth retardation do not usually occur, pituitary inhibition was suggested by an abnormal response to mepyrapone[10] in some patients on long term corticotrophin. Nelson[10] et al studied a group of 69 patients with severe rheumatoid arthritis and bronchial asthma treated with intermittent ACTH for periods of four months to five years. Clinical response was comparable to that with oral corticoids with fewer side effects and no withdrawal symptoms. Adrenal-pituitary responsiveness to metyrapone was comparable in treated subjects and controls. There was, however, a diminished immediate pituitary responsiveness to L-8 vasopressin in treated patients suggesting either a diminished pituitary corticotrophin content or some inhibition of its acute release.

Even though of limited value as a substitute for corticosteroids, corticotrophin has apparent merit during intermittent corticoid therapy and possibly at the time of steroid withdrawal. Harter[11] reported less adrenal suppression in patients on long-term intermittent day corticoids with ACTH given as infrequently as once a month. Thorn[12] recommends ACTH administration during steroid withdrawal for three to twelve weeks depending on adrenal responsiveness indicated by urinary 17-hydroxysteroid excretion. From Harter's[1] previous experience it seems that this would apply to withdrawal from long term divided dose therapy since exogenous stimulation should not be necessary with intermittent day prednisone. Other workers have questioned the value of giving ACTH at the time of steroid withdrawal.

Graber[13] studied the natural history of pituitary adrenal recovery following long-term suppression by exogenous corticosteroids and found low plasma ACTH and cortisol levels initially followed by a fairly rapid recovery in ACTH levels. Plasma 17-hydroxycorticosteroids lagged significantly behind and several months elapsed before recovery of normal adrenal responsiveness even in the presence of supranormal levels of circulating ACTH. This suggests a need for adrenal stimulation during long-term corticosteroid treatment rather than at the time of withdrawal. More evidence must be accumulated to prove that this can be accomplished with exogenous ACTH. Fleischer[14] found that 100 units of depot porcine ACTH given every two to four days for several months did not hasten recovery of normal pituitary-adrenal function after prolonged steroid suppression. Eight of nine patients receiving prolonged courses of porcine ACTH developed antibodies to corticotrophin that cross-reacted with endogenous ACTH binding it in an inactive form. This antibody, however, did not grossly alter pituitary-adrenal interrelationships in these patients.

Much controversy still exists regarding the advisability of exogenous ACTH following steroid withdrawal. But recent evidence seems to indicate that it may be worthless.

Conclusions

1. Prednisone is the corticosteroid of choice for dermatologic therapy since more expensive steroids have no real advantages in equivalent doses.

2. An intermittent day corticosteroid schedule has few associated side effects and should be used when feasible. Conversely, depot type IM corticosteroids are unphysiologic and should be avoided.

3. A single daily morning dose of prednisone may be used with minimal adrenal effect in patients requiring daily steroids for control.

4. ACTH is useful during long-term intermittent day steroid treatment but does not appear to hasten adrenal recovery during steroid withdrawal.

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739 Decatur Federal Building

GEORGIA HIGHWAY SLAUGHTER

Yearly Totals

1968 to date	248 Killed
1967	1,613 Killed
1966	1,605 Killed
1965	1,354 Killed
1964	1,314 Killed
1963	1,278 Killed
1962	1,106 Killed
1961	1,017 Killed

Through February 1968
248 KILLED

Same Period 1967
257 KILLED

February 1968
133 KILLED

Economic Loss

1968 to date	$ 47,120,000
1967	306,470,000
1966	288,900,000
1965	243,720,000
1964	236,520,000
1963	230,040,000
1962	199,080,000
1961	162,720,000

GEORGIA HIGHWAY SAFETY GRANTS APPROVED

Not much is being said about it publicly, but Georgia is rapidly taking a leading role in the nation for getting federal approval for Highway Safety grants under the National Highway Safety Act of 1966. For the second straight month, Governor Lester Maddox has announced additional grants applied for through the office of the Coordinator for Highway Safety, Ben Jordan.

Six more project applications have been approved, bringing the total for Georgia to 13. Actually, 14 project applications have been approved, but a technicality exists whereby Federal funds are allocated for 13.

The six latest project approvals include Driver Education for Lee County Schools, City of Dalton Schools, Chatham County Schools and Bibb County Schools; State Department of Education training of school bus drivers and school bus mechanics throughout the state and Police Traffic Services for the City of Decatur.

There is a total of approximately $151,900.00 of federal, state and local funds going into these six projects.

It is safe to say that Georgia leads the nation in seeking these federal funds and getting approval for these projects under the Highway Safety Act. To date, some 104 projects have been approved throughout the country, with Georgia having 13 of them.

One of the most far-reaching programs among the six projects most recently approved is the step-up in the training process in the State Department of Education involving school busses. A total of just over $33,000.00 is being poured into this program to purchase special driver training units, with the University of Georgia having offered help in developing and programming additional safety lessons for the school bus drivers and mechanics.

The use of the criteria outlined can be expected to give favorable results in a large proportion of patients.

Criteria for Surgical Treatment of Renovascular Hypertension

GARLAND D. PERDUE, JR., M.D., ROBERT B. SMITH, III, M.D., *and* JOSEPH L. PRINTZ, M.D., *Atlanta*

ENTHUSIASM FOR SURGICAL TREATMENT of hypertension of renal origin has been tempered somewhat by disappointment in failure to achieve a normotensive state in many patients. Possible explanations include (a) technical failure to accomplish revascularization; (b) renal parenchymal damage sufficient to result in persistent hypertension; and (c) operation on patients who have another cause for hypertension. Assuming a standard of technical competence, and that patients with advanced renal disease are in another category, renal revascularization operations fail to cure hypertension primarily because of improper case selection. It is well known that renal artery stenosis may be present in normotensive people and that when present in hypertensive patients, it is not always responsible for the hypertension. This has made it necessary to use increasingly stringent criteria for relating proximal renal artery disease to hypertension.

Unless advanced renal failure exists, clinical characteristics bear no consistent relationship to answering the question of whether hypertension in a given patient is caused by arterial occlusive disease in proximal renal arteries. Histologic study of renal biopsy material is not usually helpful. Therefore we have attempted to use those laboratory tests that show functional impairment of the kidney. In addition to aortography, these include the minute-sequence intravenous urogram[2] (often with urea washout[4]), the isotope renogram,[6, 7] the renal scintiscan,[3] and the Howard-Stamey[1, 5] test. All of the patients in this report had aortography and a minute-sequence intravenous urogram. When the former was positive and the latter equivocal or negative, one or more additional tests were performed. When a clear-cut positive test was obtained, additional tests were not necessarily done. Thus the Howard-Stamey test was used least frequently, since the morbidity associated with it is considerable and its reliability predicated on accurate collection of urine from both ureters. Although it is recognized that any of these tests may give both false positive and false negative results, it is believed that the likelihood of a false negative result is minimal when all tests are obtained and correlated. Any test giving clear indication of impaired function in one or both kidneys, combined with an appropriate arterial lesion, was accepted as sufficient indication to proceed with operation. Patients with a lesion on the arteriogram but no evidence of impaired function were not operated on. The purpose of this report is to review the results achieved when these criteria were used in selecting patients for surgery.

Thirty-four Operations

In a four-year period from 1962 through 1965, 34 patients had operations for correction of renal ischemia in the hope of relieving or curing hypertension. All patients had an arterial lesion demonstrated on aortography. Twenty-nine of 34 had a positive or equivocal IVP. Fifteen of 20 had a positive isotope renogram. Eight of 14 had a positive photoscan, and three of three had a positive Howard-Stamey test. Fifteen patients were males, 19 were females. The lesion producing renal artery stenosis was arteriosclerosis in 26, fibromuscular hyperplasia in six, and extrinsic compression of the renal artery by fibrous or neural bands in two. Ages ranged from 22 to 65, the median being 50.

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The duration of hypertension could not be accurately determined always. In general, hypertension was of fairly recent onset or had shown recent marked acceleration. Duration is known to have ranged from a few weeks to more than 20 years and, while prolonged duration was regarded as unfavorable, several patients with recent acceleration of long-standing hypertension responded quite well to renal revascularization.

Nine of the 34 patients had bilateral lesions. This did not appear to influence the results. Various technical maneuvers, including endarterectomy with and without patch grafting, bypass grafting, and excision and anastomosis, were used. So long as revascularization was successful, the technical method used did not appear to influence the outcome. One patient with bilateral endarterectomy had thrombosis requiring immediate reoperation; the eventual result was good. Another patient with bilateral patch grafts had unilateral thrombosis and persistent hypertension; subsequent nephrectomy resulted in cure of the hypertension.

No Operative Deaths

There were no operative deaths. Three patients died, however, at one, six, and 12 months; two died of cerebral infarction and one of myocardial infarction. Two were normotensive to time of death and one had persistent severe hypertension. Since all died of disease of the cardiovascular system, they are considered as failures for purposes of this report. Survivors have been followed for one to five years. There has been no dramatic change in any patient after one year, and those followed longer remain about as they were at the end of the one-year follow-up.

Of the 31 survivors, 19 (56 per cent) are normotensive without any antihypertensive medications. Nine patients (26 per cent) had a reduction of diastolic blood pressure of 20 mm Hg or greater but required medications to stay at a normotensive level. Three survivors had no improvement in blood pressure following surgery. These three plus those who died are regarded as failures (18 per cent). In regard to blood pressure response alone, the three living patients and the one who died with persistent hypertension give an absolute failure rate of four of 34 (12 per cent).

Failure to achieve normotension after renal revascularization when technical success is known to have been achieved implies that the criteria used in selecting these patients for operation are inadequate. It is most desirable to have a direct means of measuring angiotensin levels in the blood. This is not yet possible. Blood renin assays are performed in some laboratories but this test is somewhat complex and has not been generally available. With increasing availability of this test, it is hoped that a more accurate selection can be made. Pending this development, the use of present criteria can be expected to give favorable results in a large proportion of patients.

Summary

In patients found to have stenotic lesions of one or both renal arteries, impairment of the function of the appropriate kidney has been accepted as the basic criterion for causally relating the renal arterial lesion to the hypertension of 34 patients so selected and operated on. Nineteen are normotensive and nine more are considerably improved (82 per cent). Although a more exact standard for selecting the patient to have renal revascularization is desirable, use of the disparate function tests for selection will give a large percentage of favorable results.

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GERIATRICS SOCIETY OFFERS STUDY GRANTS TO RESIDENTS

Three $1,800 grants are being offered by the American Geriatrics Society to resident physicians who want to devote more time and effort to studying the medical problems of the aging.

The grants, inaugurated by Lederle Laboratories in 1962, will supplement the salaries the physicians receive. They will cover the period between July 1968 to June 1969.

Lederle's Director of Medical Research, Dr. William M. Sweeney, said that a great deal of basic research is needed to give us more understanding of what happens in growing tissues, what makes us age, and to what extent we can actually prevent the manifestations of aging.

Application of the grants should be addressed to the Chairman, Fellowship Committee, American Geriatrics Society, 10 Columbus Circle, New York, N.Y. 10019. Deadline for applications is May 15, 1968. Recipients will be notified on or about June 1, 1968.

Combined therapy proved more effective than did either agent used alone.

Seborrheic Dermatitis of the Scalp: A Clinical Evaluation of Combination Therapy

MARTIN I. GOLDSTEIN, M.D., *Smyrna*

THE TOPICAL APPLICATION of specific therapeutic agents has long been utilized to control and maintain seborrheic dermatitis.[1] Seborrhea of the scalp has often been recognized as an especially difficult condition in which to achieve improvement over a long period of time. With this in mind, a clinical evaluation was carried out in a series of patients with seborrheic dermatitis of the scalp comparing the effectiveness of a medicated tar shampoo (Polytar) used alone or in combination with a propylene glycol solution of fluocinolone acetonide (Synalar Solution, 0.01%).[2]

Materials and Methods

Thirty-six consecutive patients with moderate to severe seborrheic dermatitis of the scalp were alternately given Polytar Shampoo alone or in combination with Synalar Solution. These patients were requested not to use any other form of treatment. The shampoo was applied to the scalp every five or six days. In the combination therapy the Synalar Solution was applied sparingly, twice daily, in addition to the shampoo treatment. Each of the patients was followed for at least two or three months and examined biweekly.

TABLE I
RESULTS OF COMBINATION THERAPY VS. SHAMPOO ALONE

Combined Therapy No.	Combined Therapy %	Patient Response	Shampoo Alone No.	Shampoo Alone %
8	42	Complete Remission	1	6
10	53	Moderate Remission	6	35
1	5	Slight Improvement	10	59
0		Worse	0	
19	100	Total	17	100

Results

Of the thirty-six patients in the evaluation, nineteen used the combination therapy and seventeen the shampoo alone. Of those involved in the Polytar-Synalar Solution comparison, eight had a complete remission, ten had moderate improvement, and one improved slightly.

Of the seventeen patients using the Polytar Shampoo alone, one had a complete remission, six had moderate improvement, and ten improved slightly. None of the patients from either group worsened with their respective therapeutic regimens.

It is apparent that the patients using the combination shampoo-Synalar Solution therapy showed more significant improvement than those using the shampoo alone. Also of importance is the fact that patients with the most severe seborrhea of the scalp received more relief from their symptoms with the addition of Synalar Solution than by using the tar shampoo alone.

Conclusions

Thirty-six patients with moderate to severe seborrheic dermatitis of the scalp were treated with either Polytar Shampoo alone or in combination with Synalar Solution. The combination therapy proved more effective in combating the signs and symptoms of seborrhea capitis than did the shampoo used alone. The addition of the Synalar Solution was especially useful in the more severe cases of seborrheic dermatitis.

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ACKNOWLEDGEMENT

Fluocinolone acetonide 0.01 per cent was supplied as SYNALAR Solution 0.01 per cent, by Mr. Sheppard L. Masarek, Syntex Laboratories, Inc., Palo Alto, California.

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COBB COUNTY MEDICAL SOCIETY SYMPOSIUM ON HUMAN SEXUALITY

Left to right: Dr. Ralph Slovenko, Dr. Seward Hiltner, and Dr. Harold Lief, three of the speakers at the Cobb County Medical Society's Symposium, are greeted by Dr. Noah Meadows.

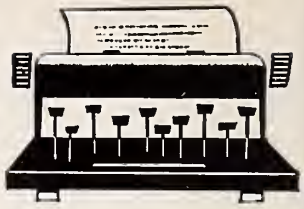
The Cobb County Medical Society's Committee on Medicine and Religion sponsored a Symposium on Human Sexuality which drew over 500 people from 12 states. People came from as far away as Pennsylvania, Kentucky and the AMA in Chicago to hear Dr. Mary Calderone, Dr. Ralph Slovenko, Dr. Seward Hiltner and Dr. Harold Lief speak. Representatives from five medical schools including the Medical College of Georgia, Emory University, Duke University and the University of Florida attended the two day meeting held March 1 and 2 at Kennesaw Junior College in Marietta. A group of medical students came from the University of Kentucky Medical Center in Lexington, Kentucky; persons from thirty-five towns and cities in Georgia and educators and counselors from many of the colleges and universities in Georgia and the Southeast attended.

Preceding the symposium, the Woman's Auxiliary to the Cobb County Medical Society sponsored several community appearances by Dr. Calderone. Dr. Calderone appeared on WSB-TV's "The Today in Georgia" show and a program was taped for the "Sound of Youth" show on WSB-TV March 10, 1968.

The symposium was covered by the Physicians News Service in New York and a story along with photographs will appear in the *Medical Tribune* in the April issue.

Plans are already under way for the 1969 symposium which will be entitled "The Year 2000—Speculation in the Areas of Medicine, Law, Religion and Education."

EDITORIALS



Rubeola: A New Antique

RUBEOLA, after generations of being accepted as a necessary part of childhood, suddenly in 1963 had a vaccine, one injection of which almost surely prevented it for life. This was accepted generally and apparently widely used. However, by 1968, it was estimated that it would still take about five years to end the disease in Metropolitan Atlanta, using the current methods employed by private pediatricians and public health clinics. Five more years of rubeola meant a considerable number of cases of serious measles pneumonia and measles encephalitis with resulting mental retardation and some deaths. With medical means at hand, it seemed to the recently formed Greater Atlanta Pediatric Society that it made sense to speed up the process of immunization and end red measles now. Medicine is sometimes, like politics, the art of the possible, and if we couldn't yet end leukemia, then at least end measles.

Means Were Available

On inquiry, it turned out that the Georgia Public Health Department had the means (about $62,500 worth) and was more than willing to get started with a mass vaccination program. Half federal, half state funds could be used, and the CDC was willing to call in their vaccine guns from various parts of the world to make the program work on the massive basis required to give injections of measles vaccine in a crash program, using an overall 40 per cent susceptibility figure for ages one through seven years.

Jaycees Publicized Program

Local Jaycees were called in close to the beginning of the organizing, and beat a wide variety of drums, exploiting every available means of publicity for the program, including newspapers, television, radio, paycheck stuffer flyleafs, and even door-to-door canvassing in the hard-core areas, aided here particularly by Poverty War block organizers. Lions Clubs made posters and signs for the clinics. Members of the pediatric society were instrumental in overall planning of the program, and a volunteer from their ranks was on hand as medical director at each clinic.

Five Teams Made Rounds

After two weeks of five daily doctor-nurse-gunner teams making the rounds of every grammar school in the five-county metropolitan area, giving the vaccine to every susceptible kindergarten, first and second grader who returned signed permission slips (17,000 doses), the program finished off with Saturday and Sunday clinics set up in most of the high school buildings (and some public health clinics) in the area, where preschoolers were brought by their parents and immunized.

With the publicity and heat generated by this city campaign, the health department has already been besieged by requests from medical societies all over the state to repeat the measles program in other areas, and feels it will take two

to three years to complete these programs. Atlanta can feel fortunate that it has been accomplished here already, and that rubeola, as of March 1968, should be an antique disease, of interest primarily historically.

Olin Shivers, M.D.
Chairman, END MEASLES
Greater Atlanta Pediatric Society

Highlights
1968 Georgia General Assembly

The 1968 session of the Georgia General Assembly has come and gone. Consuming the better part of nine weeks (officially it lasted only 40 days) the 1968 session produced some significant victories for medicine and some minor losses. The following is a brief summary of some of these bills.

ABORTION: H.B. 281, introduced at the 1967 session of the Legislature and passed by the House that year, was held over to 1968 for prolonged consideration in the Senate. This proved to be highly beneficial as the bill which ultimately passed both Senate and House was a much stronger bill containing numerous safeguards that are calculated to inspire a greater sense of confidence on the part of the people.

This bill provides that a therapeutic abortion is legal in Georgia only when the following conditions are met:

(1) The woman must be a bona fide resident of Georgia;
(2) The procedure must be performed in a hospital approved by the Joint Commission on the Accreditation of Hospitals;
(3) Three physicians must concur in the medical necessity for such procedure based on their separate examination of the woman. These concurrences must be reduced to writing, kept on file at the hospital, and at all reasonable times be available to the Solicitor General of the judicial circuit.
(4) The procedure must be approved in advance by a committee of the medical staff of the hospital created to approve (or reject) abortions.

The bill also provides for certain relatives of the woman, or the Solicitor on his own behalf, to request a declaratory judgment from the bench on the question of whether or not the legal and constitutional rights of the fetus are being violated. If the court rules that they are, then the abortion could not be performed.

Assuming each of these conditions is met, a legal therapeutic abortion may be performed in Georgia for the following reasons:

(1) A continuation of the pregnancy would endanger the life or would seriously and permanently injure the health of the woman;
(2) The fetus would very likely be born with a grave, permanent and irremediable mental or physical defect;
(3) The pregnancy resulted from forcible or statutory rape.

As of this writing, the bill must still clear the Governor's office before it is enacted finally into law.

IMMUNIZATIONS: Prior to the enactment of this bill (H.B. 871) there was no uniformity as to the immunizations which must be obtained prior to entering school. House debate on this bill produced evidence to the fact that there are five counties in Georgia that did not require a smallpox immunization. Testimony given in the Senate Committee by a group of Georgia chiropractors requested that their children be exempted from this Act on the basis that it violated

the beliefs of their "profession." This was ultimately rejected on the floor of the Senate. The bill as ultimately passed by both chambers stipulated that no child could be admitted to public school until immunized against certain contagious diseases. The State Board of Health was authorized to determine which diseases and to transmit this information to local Boards of Health who in turn must see that these are implemented.

The Act would not apply to religious objectors, or to children with a physical condition which may contraindicate vaccination.

IMPLIED WARRANTIES ON BLOOD: This bill was felt to be necessary by reason of a court decision which held that transfused blood constituted a sale and therefore subject to the implied warranties of merchantability. The medical profession had, of course, always held this to be a medical service and not a sale. This bill, H.B. 1292, introduced by Representative Carl Savage, M.D., provides that the implied warranties of merchantability and fitness should not apply to the procurement, processing, storage, distribution or use of whole human blood, blood plasma, blood derivatives or other human tissue or organs for the purpose of injecting, transfusing or transplanting into the human body. This bill was enacted.

WORKMEN'S COMPENSATION: Legislation increasing the maximum medical expenses from $2,500 to $5,000 under Workmen's Compensation was enacted. Benefits generally under Workmen's Comp were increased by the passage of this bill. This legislation has been a long time coming as industry and labor were never able to agree on the terms of an acecptable bill.

CONFIDENTIAL COMMUNICATIONS: A bill which had MAG endorsement (although not sponsored by MAG) but failed to pass would have extended the privilege of confidential communications to include those communications between physician and patient. This privilege is now provided for by statute for psychiatrists, but does not include any other medical practitioner.

TRAFFIC SAFETY: Several bills relating to traffic safety which MAG had previously endorsed were enacted. These were: S.B. 120, Implied Consent; Pursuant to this bill, a driver is presumed to have given his consent to be tested for the level of alcohol in this blood to determine if he is, in fact, intoxicated. Such test would be ordered by a law enforcement officer when suspicion of driving-under-the-influence is present. Failure to submit to the test would result in revocation of drivers permit.

H.B. 881, Point System; Traffic violations are assigned point value and upon the accumulation of a certain point total a drivers permit is suspended or revoked.

H.B. 843, Radar; Authorizes use of speed timing devices by municipalities with safeguards written into law to prevent "speed trap" abuse.

H.B. 839, Reflective License Plates; Authorizes Revenue Directors to design and sell automobile license plates that reflect light in an effort to reduce rear end collisions during night driving.

PSYCHODRAMA: S.B. 174, a bill to license people "qualified in the use of psychodrama" was not enacted. This bill would have authorized non-physicians to engage in the practice of treating mentally disturbed people by showing them how to act out their frustrations.

FREEDOM OF CHOICE OF M.D. OR THERAPIST: This bill, H.B. 1106, would have provided by statute for the complete freedom of choice of physician or therapist under any and all accident and sickness insurance contracts as well as under Workmen's Compensation. Freedom of choice within the meaning of this bill would have included chiropractors, optometrists, naturopaths, etc.

The foregoing list of bills by no means covers all the legislation which MAG followed closely throughout the two year life of the recently adjourned legislative term. In all there were over 50 bills of interest to MAG. All legislation not enacted prior to adjournment on March 8 died with this session of the General Assembly. No bills will be carried over until next year and must of necessity be introduced again and run the full course of the General Assembly before they can become law.

An Intelligent "Square's" Guide Through Adolescence

SOME MEN AND WOMEN in their 40's and 50's are putting themselves through for a "second-time" anxiety; even the agonies of what is now called the "identity crisis"—it used to be called "growing pains."

While the lucky parents can dissolve their value system and re-establish one that does not make their whole past life seem futile, the unlucky ones may look back on the various crossroads of life and think, too late, that they took the wrong turn.

These "now over 40" are often burdened by their late Victorian parents with a harsh conscience, and a tendency to overblame themselves. They are sandwiched between a generation that questioned too little and a generation that questions too much. They themselves never had the white meat of the turkey. When they were children, the best parts were saved, as a matter of course, for the adults; by the time they grew up, the best parts were being saved, as a matter of course, for the children. So having been children in an adult-centered world, they are now adults in a child-centered world. And how do they react to finding themselves in this historic tide of values? BY FEELING GUILTY.

How can "square parents" possibly survive this ordeal?

(1) They must fight guilt and despair, since these are likely to be both inappropriate and counterproductive. Just as parents cannot predict the form of rebellion chosen by the next generation, so they are not individually responsible for it.

(2) They should rely on that tough effective teacher, the parents' ally: *EXPERIENCE*. The young person who refuses to learn the easy way will simply have to learn the hard way. But that gnarled old teacher, experience, has tended over the generations to keep the same lesson plan: That the work one loves can be more fun than fun, and that permanent relationships grounded in loyalty are vastly preferable to ephemeral ones.

(3) Learn to distinguish between parental affection and approval: affection is built in, approval must be earned. Though the parents may never fully approve of their grown child—or vice versa, a family, like a nation and a world, can, with effort, make room for diversity.

(4) Try to give an object lesson in tolerance and humor, cheerfully and admittedly borrowing those attitudes that will come in handy for the time of retirement. Even before retirement the square may wish to shed some encrusted bugaboos, such as compulsive punctuality or servitude. Indeed his health may benefit if he learns, as the young say to "hang easy."

(5) To have hope, that within the two years it usually takes for diminishing returns to set in, your adolescent will emerge from the dangerous Children's Crusade of his time, the better prepared to cope in middle age with the gyrations of his and his children's century.

Herbert S. Alden, M.D., and Paul C. Cronce, M.D., Atlanta
(Some portions taken from an article in The New York Times Magazine, September 24, 1967)

For Your MAG 1968 Annual Session Hotel and Motel Reservations

APPLICATION FOR HOTEL AND MOTEL ACCOMMODATIONS

Medical Association of Georgia 114th Annual Session

May 5-7, 1968—Augusta, Georgia

A HOUSING BUREAU has been established for your convenience in making hotel and motel reservations at Augusta for the 1968 Annual Session of the Medical Association of Georgia. Comparable room rates and accommodation information are listed. *Use the Reservation Form below.* Please specify your first, second and third choice hotel or motel. All requests for reservations should give: (1) anticipated date and hour of arrival; (2) date and approximate hour of departure; (3) names and addresses of all persons who will occupy the accommodations. All reservations must be cleared through the Housing Bureau. Since all requests for rooms will be handled in chronological order, you should mail your application as early as possible to secure the accommodations you request. All reservations will be confirmed.

Augusta Town House: Broad at Albion St. (722-5541). **Single $8-12, double $12-18, $3 for extra person occupying room.** 100% Air Conditioned, Swimming Pool, TV-Radio, Free inside parking, Barber and Beauty Shop, Two Cocktail Lounges, Two Restaurants, Newsstand, Gift Shop, Package Shop—Heart of Augusta—300 Rooms.

Towers: Single $14, double $16.

Downtowner Motor Inn: Reynolds at 8th St. (722-5361). **Single $9, double $12, twin beds $14.** 100% Air Conditioned, Radio-TV, Free parking. Swimming pool, Cocktail Lounge, Restaurant—100 rooms.

Warrick—Quality Motel: Broad at 4th St. (722-0212). **Single $10, double $14, twin beds $14.** Air Conditioned—TV, Free Parking, Free Continental Breakfast. Cocktail Lounge—69 Rooms.

University Motel: 1410 Gwinett St. (724-8204). **Single $7, double $9, 2 double beds $12.** Air Conditioned—TV, Free parking, Restaurant near-by, Adjacent Talmadge Memorial and University Hospitals—68 Rooms.

Medical Center Motel: 1480 Gwinett St. (722-4828). **Single $8, double $12, triple, $16.** Air Conditioned—TV, Free Parking, Restaurant next door, Adjacent Talmadge Memorial and University Hospitals—45 Rooms.

Howard Johnson Motor Lodge: 1238 Gordon Highway. (724-9613). **Single $10, double $12, twin beds $15.** Air Conditioned—TV, Swimming Pool, Free parking, Restaurant and Cocktail Lounge—61 Rooms.

Holiday Inn: 1602 Gordon Highway (798-2782). **Single $10, double $13, 2 double beds $15, $2 for extra person occupying room.** Air Conditioned—TV, Swimming Pool, Restaurant, Cocktail Lounge, Free Parking—110 Rooms.

Confirmation of your request for accommodations will be in accordance with preference indicated, if possible; if not, best substitutes will be made. Deposit of one day's room rent will be required with each request for accommodations.

Cut out and send to: Please Type or Print

HOUSING BUREAU, MEDICAL ASSOCIATION OF GEORGIA
Augusta Town House, Augusta, Georgia—Attn: Reservations Manager

Please reserve the following accommodations for the 1968 Annual Session of the Medical Association of Georgia.

Hotel or Motel Preference

1st Choice ..... ☐ Double Room at $ ..... to $ .....

2nd Choice ..... ☐ Double Room at $ ..... to $ .....

3rd Choice ..... ☐ Twin Bedroom at $ ..... to $ .....

☐ Other type .....

Arrival Date ..... Hour ..... A.M. ..... P.M.

Departure Date ..... Hour ..... A.M. ..... P.M.

THE NAME OF EACH HOTEL GUEST MUST BE LISTED. Include all names of all persons for whom you are requesting reservations and who will occupy the room(s):

Name of Occupant(s)	Address
.....	.....
.....	.....
.....	.....

Individual Requesting Reservations

Name .....

Address .....

City ..... State .....

Zip Code .....

If hotels or motels of your choice are unable to accept your reservations, the Housing Bureau will make reservations to fit your specifications elsewhere.

ATTORNEY GENERAL OFFERS OPINION ON PRESCRIPTION OF DRUGS

RECENTLY, THE DIRECTOR of the Georgia Department of Public Health petitioned the Attorney General for an opinion on various questions pertaining to the prescription of drugs under the Title XIX (Medicaid) program.

I would like to cite one question and the answer offered by the Attorney General:

QUESTION: "Which practitioners of the healing arts are authorized under Georgia law to prescribe those drugs which are obtainable only by prescription?"

ANSWER: "There would appear to be no doubt as to the legal authority of Medical Practitioners, Dentists, Podiatrists (Chiropodists) and, in the prospective sense, Nurses, to prescribe such drugs as are generally accepted as being necessary or incidental to the practice of their particular branches of the healing arts. With respect to Osteopaths, the situation is wholly unclear and virtually cries out for legislative clarification. Osteopaths are prohibited by statute from prescribing *narcotic* drugs for purposes other than the alleviation of pain. While the statutory silence respecting their prescription of other (i.e., non-narcotic) drugs would logically seem to imply that, like Dentists, they are authorized to prescribe such drugs as are generally accepted as being necessary or incidental to the practice of osteopathy, the picture is clouded due to certain judicial decisions rendered some years ago when this branch of the healing arts was ordinarily thought of as being confined to treatment by means of manipulations applied to the body structure and not, as it is today, thought of as encompassing surgery, obstetrics, etc., as well as the prescription of drugs necessary and incidental to the practice of the Art. Whether these older decisions would be followed today, of course, is highly questionable."

In discussion, the Attorney General cited other representatives of the healing arts which are expressly prohibited from prescribing drugs—Chiropractors, Optometrists, Physical Therapists, Naturopaths, and licensed Applied Psychologists.

At the March Council meeting, MAG attorneys thoroughly reviewed the ruling, expressed doubt as to its soundness and stated that clarification should be sought. Council authorized the attorneys to confer with the Attorney General as a first step in resolving the matter.

John T. Mauldin, M.D.
President, Medical Association of Georgia

CANCER PAGE

ADVANCES IN THE THERAPY OF CHILDHOOD CANCER

W. LORRAINE WATKINS, M.D., ***Atlanta***

CANCER'S ROLE AS THE MAJOR KILLER (excluding accidents) of children indicates its significant frequency in the younger age groups. Continuing increases in cure and remission rates in childhood cancer are offering greater yields in preservation and prolongation of normal life as the result of exercise of diagnostic and therapeutic skill by the physician.

The empirical development of actinomycin D as an adjuvant to surgery and radiotherapy of primary Wilms' tumor has resulted in a well documented increase in cure rates from 40 per cent to the 70 to 80 per cent ranges. Although at this point insufficient data are available to calculate a rate, it is apparent that a significant number (perhaps 50 per cent) of the children with metastatic lesions of this tumor are also being cured with aggressive use of combination radiotherapy and chemotherapy and in some instances surgery.

Neuroblastoma Common in Childhood

Neuroblastoma, also a common malignant tumor of childhood, tends to be generally responsive to multiple therapeutic approaches with 40 to 60 per cent being curable as long as marrow or bone metastases are not present. Unfortunately, over 50 per cent of these children present initially with metastases in these locations, lowering their chance of cure to less than 0.1 per cent. The discovery of the frequently elevated excretion of the metabolites of norepinephrine and dopamine in some patients afflicted with neuroblastoma is now, however, leading to earlier diagnosis, improved disease activity monitoring, and hopefully higher cure rates.

Primary retinoblastoma has for several years been yielding to the combined approach (surgery, radiotherapy, and chemotherapy). However, the invariably fatal outcome of metastatic disease demands early diagnosis as well as intensive therapy.

Soft tissue and bone sarcomas comprise the majority of the other solid tumors seen in childhood. Curative therapy of these tumors is at this time generally unsatisfactory though small numbers are apparently cured with aggressive and usually combined treatment.

Cure Requires Total Cell Kill

Data regarding transplanted mouse leukemia cell kinetics and relationship to response and potential curability with a variety of chemotherapeutic agents are suggesting a rational approach to the therapy of malignant disease in humans. These data appear to express two important points: 1) a "100 per cent cell kill" is necessary before cure results, and 2) (in the case of leukemia) large dose and/or combination drug therapy is more likely to accomplish this. Human data obtained thus far regarding the response to and the pharmacology of specific drugs, drug dosages, and drug combinations are confirming the presence of at least some parallels between animal and human leukemias. It is also evident that chemotherapy can better be tolerated at higher dosages during periods of complete remission

than during periods of clinical activity of the disease. Utilization of these as yet relatively fragmentary data has already resulted in complete remission rates of 90 to 95 per cent in acute leukemia in children with prednisone and vincristine in combination. The utilization of intermittent high dose maintenance therapy such as with methotrexate during periods of remission is in general extremely well tolerated and is resulting in median duration of first remission in excess of 12 months. Empirical reutilization of inducing agents such as prednisone and vincristine is resulting in greater frequency of second, third, fourth and fifth complete remissions. The problems of bone marrow and immunologic inadequacy during periods of intensive therapy as well as during disease activity are being attacked and one serious problem, i.e., serious hemorrhage due to platelet deficiency, has been at least partially solved. As more information regarding exact mode of action of chemotherapeutic agents and supportive therapy becomes available, it is anticipated permanent cure will become possible.

Emory University

PHASE II–GRMP APPLIES FOR OPERATIONAL GRANT

As reported in the December issue of *JMAG*, the first year of planning for the Georgia Regional Medical Program is drawing to a close and the second phase of the program—the operational phase—is ready to be initiated.

Following their appointment in June of 1967, the primary or disease-oriented task forces of GRMP were directed to make reports and recommendations to the coordinating task forces to be developed into a broad general plan for the operational phase of the Program.

Suggestions from the Regional Advisory Group and from local advisory groups were received and considered. Voluntary health agencies, organizations and institutions concerned with health care were contacted, their current activities in each disease area explored and their suggestions for needed improvement and possible cooperative endeavors obtained.

On January 21 of this year, the Steering Committee and task force chairmen met to approve and/or modify project proposals to be included in the Operational Grant Application.

Priorities for action were recommended which were then submitted to the Regional Advisory Group for final approval on February 25. The Advisory Group reviewed the progress of the program to date, the plans for the coming year and the operational projects in the grant application and expressed its approval of both the report and the request for funds.

The grant proposal, which had a total overall budget for the first 12-month period of slightly less than $2 million, was then submitted, on March 1, through the Medical Association of Georgia to the Division of Regional Medical Programs at the National Institutes of Health in Washington. Here it will be examined by the primary review committee and then submitted to the National Advisory Council for consideration.

If approved by the NAC and the Surgeon General, funds will be awarded through the DRMP to the Medical Association which serves as the fiscal agent for GRMP. The projects will then be implemented by the GRMP staff. It is anticipated that notification of approval will be received about June 15 at which time a detailed description of each of the initial operational projects will be announced.

On March 24, the Chairmen of all local advisory groups throughout the region met in Atlanta for a review of the Operational Grant Request and a summary of progress to date on both the National and Regional levels.

Meanwhile, the GRMP staff and task forces are already discussing projects to be submitted in the August 30, 1968, Operational Grant Request. Final project proposals must reach the GRMP office prior to June 1, 1968. The task forces will review the proposals and make their recommendations to the Steering Committee in August which will then submit the new operational grant proposal to the Advisory Group for review and final approval.

Although health planning has been going on in this region for many years, this is the first time that representatives of all interested groups have deliberated together in an attempt to coordinate their health care planning into a unified plan for progress. The interest and participation of practicing physicians, local hospitals and the medical schools has been excellent. Close communications with other agencies, organizations, institutions and government programs are assuring complete coordination of all activities in the area of health in the Georgia Region and the purposes of Public Law 89-239 are being achieved.

PRIMARY MYOCARDIAL DISEASE

C. VERNON SANDERS, M.D., *Atlanta*

THE TERM "PRIMARY MYOCARDIAL DISEASE" was developed to include those disorders of uncertain etiology that involve only the heart muscle. Conditions that affect other portions of the heart are not included in this category. It is a descriptive term that has served to unify a rather awkward nomenclature. As clinical awareness of this disorder has increased, numerous reports bearing different titles have appeared in the literature. Although there may be shades of difference in historical accounts, clinical presentations, and microscopic changes within the heart, many cases find a common place within the spectrum of disease affecting heart muscle "primarily."

When the disease is moderately advanced, the clinical features are easily recognized. They are predominantly those of cardiac enlargement and biventricular congestive heart failure. However, during the indolent phase, symptoms are mild, and an erroneous diagnosis may be made unless a high index of suspicion is held. The same maxim applies to the asymptomatic patient with unexplained cardiomegaly or an unexplained arrhythmia, particularly multifocal premature ventricular contractions and various degrees of heart block.

Pathologic Changes

Pathologic changes, though variable, have many features in common. Various degrees of fibrosis, residual of an earlier inflammatory process, are often present. The paucity of cellular infiltrate underscores the chronicity of the process. Hypertrophy of individual muscle fibers may be striking. Heart weights in excess of 700 gm. are not unusual. Focal subendocardial thickening (including the papillary muscle) is common and occasionally is the dominant pathologic change. These alterations provide the nidus for intracardiac mural thrombus formation and the subsequent occurrence of emboli to the pulmonary and/or systemic arterial tree. Thickening of the pericardium, which occurs in many instances, reinforces the concept of a pancardiopathy.

The prognosis of patients with this condition is quite variable. Treatment is non-specific and is primarily the management of the congestive heart failure with digitalis, diuretics, low sodium diet, and decreased physical activity.

The pathogenesis of primary myocardial disease of the idiopathic variety remains obscure. There are probably several etiological fctors. It is unlikely that a single common denominator is responsible for all cases. A great deal of interest has recently centered around the possible role of an infectious-immune mechanism. Several observations support such a concept. First, it is unreasonable to assume that the Beta-hemolytic streptococcus is the only infectious agent that can initiate a hypersensitivity reaction resulting in acute and chronic myocardial disease. Second, the development of inflammatory heart disease following various infections is a valid clinical observation. Similarly, transition into a chronic phase of the disease has been noted for many years. Experimental evidence to support this concept includes the demonstration of fluoroscein labeled bound gamma globulin in the hearts of some patients with primary myocardial disease. Recently, the production of the disease in guinea pigs following exposure to homologous antigen (hearts

from animals infected by a Coxsackie B-3 virus) provides an additional inference. Further investigation in this area may clarify an underlying mechanism in the production of primary myocardial disease.

6363 Roswell Road

MEDICAL ART CENTER TO BE ESTABLISHED

The establishment at the Philadelphia Museum of Art of an international medical art center of prints and related illustrative medical material with an accompanying research reference center has been announced by Dr. Evan H. Turner, Director of the Museum.

The complex, to be know as the Ars Medica Center, was made possible through a major grant from the Smith Kline & French Foundation, the educational and scientific trust of Smith Kline & French Laboratories of Philadelphia.

Development plans include the expansion of the Museum's outstanding collection of prints and drawings relating to the medical sciences and the creation of a center for pictorial research in subjects pertaining to the history of medicine and allied professions such as dentistry, pharmacy, veterinary medicine, etc. Through an informational retrieval system, both the original and some non-original visual material such as photographic archives, slides, etc. will be readily accessible for reference, study, exhibition, and loan.

PSYCHIATRISTS MEET TO STUDY LEGAL ASPECTS OF PRACTICE

The winter meeting of the Georgia Psychiatric Association was concerned with Psychiatry and the Law. Meeting with the lawyers at the Regency Hyatt House in Atlanta in mid-February, the members heard Dr. Modlin of the Menninger Foundation in Topeka, Kansas, speak on a panel entitled "Various Aspects of Psychiatry and the Law."

New officers, who will take office in May, were elected at the meeting. Sweeney Sikes of Macon will succeed August S. Yochem of Atlanta as President and Mark Gould of Smyrna will become President-Elect.

Dr. Yochem commented on the large attendance at the meeting and said that it was the most well attended one to date. The Georgia Psychiatric Association now has 155 members.

S.S. HOPE SAILING TO COLOMBO, CEYLON

The hospital ship S.S. HOPE sails this month for Ceylon to begin the project's most comprehensive medical teaching and treatment mission to date.

The ship departed February 29 from Philadelphia, and arrives in Colombo, Ceylon, on April 15. Enroute the HOPE stopped at Fort Lauderdale, Florida, for two days of public tours and official farewell ceremonies.

In Ceylon, the HOPE team of 150 physicians, dentists, nurses and technicians will work for ten months with Ceylonese medical counterparts. The arrival of the ship was preceded in June 1967 by a visit of a HOPE survey team which met with Ceylonese officials to determine needs and to outline an educational-exchange program. In January 1968 an advance team of HOPE permanent staff members flew to Colombo to prepare for the ship's arrival.

In Ceylon the S.S. HOPE will serve as an affiliated hospital to the medical schools and to the hospitals in Colombo and the inland city of Kandy. Patients will be referred to the ship by a HOPE committee made up of Ceylonese medical professionals. HOPE medical teams will work with their counterparts not only on the ship, but in clinics, classrooms and hospitals ashore.

HOPE goes to Ceylon at the invitation of the Ceylonese government and the Ceylonese medical profession. The mission marks the ship's first return to Asia since the maiden voyage to Indonesia and South Vietnam in 1960. Since then, HOPE has visited Peru, Ecuador, Guinea, Nicaragua and Colombia. HOPE shore-based programs continue today in four of those nations.

Founded in 1958 by Dr. William B. Walsh, Project HOPE is the principal activity of The People-to-People Health Foundation, Inc., an independent, non-profit corporation supported by the American people. Since the first voyage, more than 1,100 American medical personnel representing all fifty states have served with the Project. The HOPE staff has trained 4,017 medical personnel, treated over 120,000 persons, conducted some 10,778 major operations, and benefitted more than two million people through immunization, examinations and other services.

LEGAL PAGE

LEGAL ASPECTS OF THE EMERGING ROLE OF THE PROFESSIONAL NURSE

JOHN L. MOORE, JR., ***Atlanta****

In the last two decades, the practice of medicine has evolved into fields of specialization based on higher knowledge and technology. With this specialization comes the use of paramedical personnel with advanced training and skills to perform functions which twenty years ago were performed by the physician. Certainly, in this course of specialization and the use of paramedical personnel, the nurse's role has changed and as a general rule physicians favor the expanding role of the nurse.

Also in the last few years, many interesting developments have taken place. In some court cases, nurses and other paramedical personnel have been held negligent for not taking steps to overcome the negligence of medical doctors. This writer discussed at length one such case in the February 1966 issue of *J.M.A.G.* entitled "Hospital Held Liable." In that case, the physician was held liable for negligence for not having removed a cast sooner and the hospital, through its nurses, was held liable for negligence on the part of the nurse for not having taken the matter to the Chief of the Medical Staff for the purpose of having him require the attending physician to seek consultation. To say the least, this decision has extended previous frontiers of hospital liability through the emerging role of the nurse.

Following are other examples where the nurse's role in the last decade has taken over some of the features of medical practice.

Intravenous Injections

From time immemorial nurses have administered hypodermics. Today it is uniform and accepted practice for a properly trained nurse to give intravenous injections provided the nurse administers the exact dosage prescribed by the physician; the nurse has training sufficient to recognize adverse reactions and to react as required by this training; and the physician authorizing the nurse to give the intravenous injection is cognizant of the fact that he assumes full risk to the same extent as if he gave the injection himself.

In discussing the question of intravenous injections, a differentiation must be made between the unauthorized practice of medicine and liability because of malpractice. This writer submits that the giving of intravenous injections is not the authorized practice of medicine if given in the above circumstances. The question of liability is entirely different, but it seems that a physician should not now be held to be liable for negligence by allowing a nurse to give such an injection even if the injection were otherwise properly given. The plaintiff needs to go further to show that the intravenous injection was negligently administered. In *Bauer v. Otis,* 133 Cal.App.2d 439, 284 P.2d 133 (1955), the plaintiff sued for damages when he received an injection given by a nurse and suffered "wrist drop." The court held that the wrist drop could only have occurred because of negligent administration of

** Prepared at the request of The Medical Association of Georgia. Mr. Moore is a partner in the firm of Alston, Miller & Gaines, General Counsel to The Medical Association of Georgia.*

the injection and in no place apparently did the plaintiff argue, or the court suggest, that the physician allowing the nurse to give the injection was liable per se for the administration of the injection by the nurse.

Blood Transfusions

It is now usual and customary in hospitals for nurses to administer blood transfusions. Apparently the issues and safeguards are the same as those set out above with respect to intravenous injections with one difference. Blood transfusions result in a morbidity of .1 per cent, the same as appendectomies. The risk of morbidity in blood transfusions seems to be equal to that of a fairly major operation.

Cardiac Arrest

The nurse of this decade should be sufficiently trained to give resuscitation and first aid to patients suffering cardiac arrest while awaiting the arrival of the medical doctor. This would certainly include the use of closed chest heart massage by the nurse who is able to learn the procedure; however, the nurse should not perform thoracotomies.

Intensive Cardiac Unit

The general attitude of physicians to the emerging role of the nurse is reflected in an article appearing in the February 1968 *Journal of The Medical Association of Georgia* entitled "Coronary Care Units in Small Hospitals." Throughout this article the writers speak of nurses and their training for this duty. While the law seems a little slow in catching up with the concepts of the practice of medicine, it is entirely clear that physicians and hospitals do, and should, regard as usual and customary the services a nurse performs pursuant to general orders of physicians in intensive cardiac units.

Another Kind of Example

It is interesting to see that in the last two decades there has been one development the other way. In the 1940's, it is probable that most surgery was performed with the anesthetics being administered by a registered nurse. In larger cities at the present time, it is probable that it is much more usual and customary for anesthetics to be administered by a licensed physician specializing in anesthesiology. This practice has become so common in metropolitan centers that in the future there may be some question as to the failure to follow usual and customary practices if a nurse is used to administer anesthetics.

Summary

At this stage, the question might be raised as to where do we go from here? Generally speaking, the answer to that question is the answer to all questions in the practice of medicine and nursing—no antiquated principle of law should ever interfere with a practice which serves the patient best.

Some people have suggested that the Legislature or the State Board of Medical Examiners or the State Nursing Board should promulgate additional laws and regulations on this subject. Such a procedure always tends to cause a delay in the law or regulation keeping up with practice. It would seem preferable to this writer that a voluntary organization be formed composed of representatives of The Medical Association of Georgia, the Georgia Hospital Association, the Georgia State Nurses Association, the Medical and Nursing Schools in the State of Georgia, and the University System of Georgia. Such a committee should define the scope of practice, essentially saying what is "usual and customary" as to the emerging role of paramedical personnel. In addition, such a committee might well discuss what the scope of practice should be in coming years. Such a

committee should also recommend the educational and training qualifications necessary for the performance of particular functions by the particular paramedical personnel. The representation of medical and nursing schools and the University System of Georgia is made to suggest that it would be desirable for the same committee to promote appropriate training programs.

Suite 1220
C & S Bank Building

THIRD DISTRICT AND MUSCOGEE SOCIETIES PLAN FULL DAY PROGRAM APRIL 18

The Third District Medical Society and the Muscogee County Medical Society plan a full day's program on April 18. The morning session will begin at 9:00 a.m. at the Medical Center and the afternoon session, to begin at 2:00 p.m., will be held at the Ralston Motor Hotel in Columbus.

The guest faculty will include Robert Kibler, M.D., Professor of Medicine (Neurology) at Emory University School of Medicine in Atlanta; James W. Pate, M.D., Professor and Chairman, Thoracic Surgery Section, University of Tennessee School of Medicine, Memphis; and Nathan Salky, M.D., Associate Clinical Professor of Medicine, University of Tennessee School of Medicine, Memphis.

The morning session will include several talks by local physicians as well as the Medical Grand Rounds, the Surgical Grand Rounds and a tour of the Cobalt Unit, Laboratory, and Cardiac Unit.

At the afternoon session, the guest faculty will speak. Dr. Salky will speak on the "Nutritional and Medical Aspects of Arteriosclerosis," Dr. Pate will speak on "Coronary Artery Arteriosclerosis and Surgical Therapy," and Dr. Kibler's subject will be "Cerebral Arteriosclerosis." Discussion and questions will follow and at 5:30 p.m. a social hour will be held.

PRIMATOLOGY CONGRESS SET FOR ATLANTA

Some of the world's foremost scientists in the areas of the non-human primate are scheduled to attend the Second International Congress of Primatology in Atlanta June 30-July 3, 1968.

The meeting will be held as a memorial honoring Dr. Robert M. Yerkes, founder of the Yerkes Regional Primate Research Center now located at Emory University in Atlanta.

Dr. Geoffrey H. Bourne, Yerkes director, said the participants will include Drs. L. S. B. Leakey and Raymond Dart who are famous for their studies in Central and South Africa into man's evolution from lower primates.

Also expected to deliver a banquet speech on Russian primate research is Dr. Boris Lapin, director of the Soviet Union's primate center at Sukhumi, U.S.S.R.

Scientists also are expected from England, France, Holland, West Germany, Italy, India, Japan, Switzerland, Sweden, Canada and South America, Dr. Bourne said.

Scientific sessions will be held at the Biltmore Hotel with special visits planned to the Emory campus and to the Yerkes center.

Dr. Yerkes, a professor of psychology at Yale University, initially established the primate center in Orange Park, Fla. It was moved to Emory in 1965.

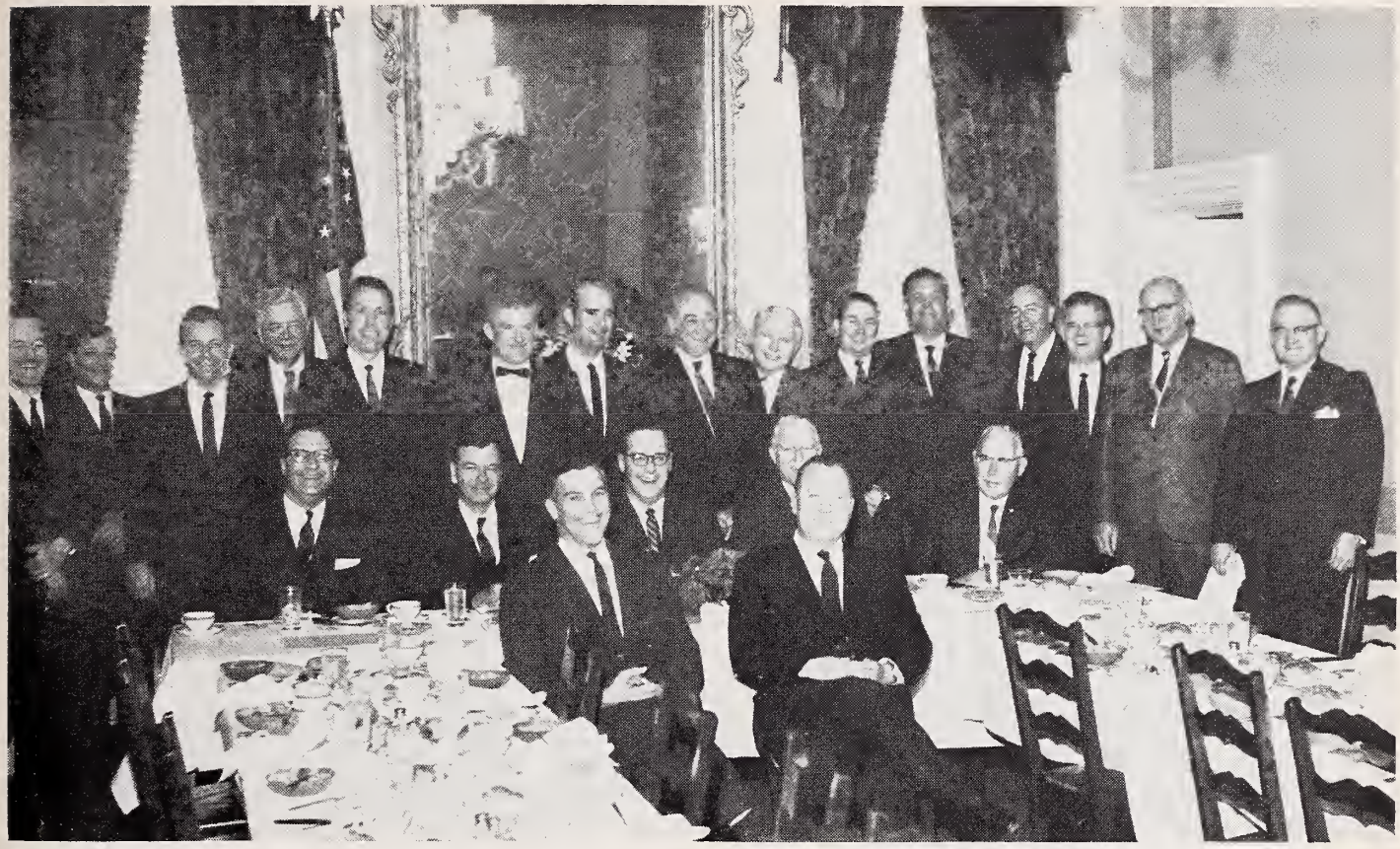
MASSACHUSETTS PHYSICIANS REQUEST CASE HISTORIES

The ability of physicians to maintain life for very long periods in the unconscious patient raises the question as to how long such skills should be deployed. As physicians we are eager to promote the recovery of everyone who can do so. In order to deprive no one of his chances on this score it is relevant to know the longest periods of coma which have been followed by useful survival.

A committee of the Massachusetts General Hospital is studying our own records and the world literature to determine pertinent features in all patients who, *despite coma for over five weeks*, have made a useful recovery. We think it is vital not to overlook any well documented patient in this category. We should be grateful if any reader of this journal would draw our attention to any case published under a title which is not indicative of survival after prolonged coma. We are also eager to receive accounts of such cases as yet unreported. A publication incorporating our own and others' data is planned.

William H. Sweet, M.D.
Chief, Neurosurgical Service
Chairman, Committee on Management of the Unconscious Patient
Massachusetts General Hospital
Boston, Massachusetts 02114

MAG PHYSICIANS HOST GEORGIA CONGRESSIONAL DELEGATION AT CAPITOL LUNCHEON



Standing, left to right: Luther Vinton, M.D., Decatur; J. D. Bateman, M.D., Albany; Rep. Benj. Blackburn, 4th District; Rep. Maston O'Neal, 2nd District; Rep. Jack Brinkley, 3rd District; Bruce Newsom, M.D., Columbus; Wm. Dowda, M.D., Atlanta; Rep. Phil Landrum, 9th District; Neal Yeomans, M.D., Waycross; Carson Burgstiner, M.D., Savannah; Rep. Elliott Hagan, 1st District; J. L. Mulherin, M.D., Savannah; Earl McGhee, M.D., Dalton; Charles Andrews, M.D., Canton; and Herbert Alden, M.D., Atlanta. Seated, back row, left to right: James Kaufmann, M.D., Atlanta; Senator Herman E. Talmadge; J. Frank Walker, M.D., Atlanta; Rep. John J. Flynt, 6th District; and T. A. Sappington, M.D., Thomaston. Seated, front row, Rep. Fletcher Thompson, 5th District; and Rep. John Davis, 7th District.

For the tenth consecutive year Georgia physicians, under the leadership of the MAG Legislative Committee, hosted the Georgia Congressional Delegation at an informal luncheon in Washington on March 8.

A doctor from each of Georgia's Congressional Districts attended the luncheon to act as personal host to his Congressman. The reception accorded the group was warm, friendly, informative and mutually productive. Legislative Committee Chairman J. Frank Walker served as Master of Ceremonies for the luncheon and "trail boss" for the trip in general.

The group flew to Washington the night before the luncheon to permit an early start the next morning. The events of the day began with an "early bird" briefing by the staff of the AMA Washington Office in preparation for the visits to the Congressmen's offices which followed.

The luncheon, at noon time affair, was held in the Speaker's Dining Room at the Capitol and was arranged through the good offices and kind efforts of Sixth District Congressman John J. Flynt, Jr.

In brief remarks at the luncheon, Dr. Walker outlined the attitude of Georgia physicians on a variety of Federally sponsored health and medical programs and assured his Congressional guests of the medical profession's continued determination to work for the best interests of patient care. In turn, each of the Congressmen spoke briefly on subjects ranging from foreign affairs to the President's recent Health Message to the Congress. All members of the Georgia Delegation were present except Congressman Robert Stephens who was absent from Washington due to a prior commitment and Senator Russell who was detained on the floor of the Senate.

A new wrinkle was added to this year's luncheon trip. For the first time, the Congressional luncheon was scheduled to coincide with the AMPAC National Workshop which was held on March 9 and 10, the days following the luncheon. Under the joint leadership of Dr. Walker for Legislation and Dr. Earnest Atkins for GaMPAC, the two groups complemented each other's efforts by greatly increasing the number of participants at the AMPAC Workshop and by giving exposure to the political process to those who attended the luncheon.

This double-barreled, two-pronged foray into the political heartland of the nation proved to be a highly successful combination endeavor. The luncheon as an exercise in Congressional PR was superb. Add to this the informative and inspirational aspects of the AMPAC Workshop and one must conclude that this was the best of the ten.

SAN FRANCISCO AMA '68

The excitement of San Francisco's famous sites is waiting for you. Chinatown, the Golden Gate Bridge, Fisherman's Wharf, Telegraph Hill, will add to five memorable and stimulating convention days. Plan to attend now and look forward to an excellent convention in a city of unlimited charm.

Continue your postgraduate education with a varied program of • four General Scientific Meetings on Auto Accidents, Health Care Planning, Infectious Diseases, Treatment of Advanced Malignant Disease • 23 Section Programs • Color Television • Medical Motion Pictures • and over 600 scientific and industrial exhibits. All are designed to bring you up-to-date on what is making medical news today. You will attend lectures by the nation's outstanding medical authorities and discuss with them the significant advances in medicine.

In addition the AMA TV network will present more than 40 hours of convention news.

Reserve now for the Scientific Awards Dinner in honor of the Scientific Award Winners—Wednesday, June 19, 1968. Since space is limited, we suggest you make your reservations before June 3, 1968. Tickets are $10.00 each, payable in advance.

The complete scientific program, plus forms for advance registration and hotel accommodations, will be featured in JAMA, May 6, 1968.

SAN FRANCISCO, CALIFORNIA · JUNE 16-20, 1968

AMERICAN MEDICAL ASSOCIATION'S 117th ANNUAL CONVENTION · BROOKS HALL

NEW MEMBERS

Abrams, Norman, M.D. DE-2—Fulton	1256 Briarcliff Road, N.E. Atlanta, Georgia 30306
Adams, John B., Jr., M.D. Active—Flint	408 E. Third Avenue Cordele, Georgia 31015
Ballard, Marvin K., Jr., M.D. Active—Flint	412 Church Street Vienna, Georgia 31092
Bohanan, G. Wayne, M.D. Active—Bibb	Macon Hospital Macon, Georgia 31201
Bowen, Edward G., M.D. DE-2—DeKalb	80 Butler Street, S.E. Atlanta, Georgia 30303
Bush, Leon H., M.D. Active—Dougherty	403 W. Broad Ave. Albany, Georgia 31701
Chaviano, F. A., M.D. Active—Troup	301 Broome Street La Grange, Georgia 30240
Cooper, R. Dale, Jr., M.D. Active—Fulton	265 Ivy Street, N.E. Atlanta, Georgia 30303
Echemendia, Mariano M., M.D. Active—Fulton	384 Peachtree Street, N.E. Atlanta, Georgia 30308
Flowers, Nancy C., M.D. Active—Richmond	VA Hospital Augusta, Georgia 30904
Garcia, P. F., M.D. Active—Fulton	811 Juniper Street, N.E. Atlanta, Georgia 30308
Harper, William N., M.D. Active—Fulton	250 Auburn Avenue, N.E. Atlanta, Georgia 30303
Horan, Leo G., M.D. Active—Richmond	VA Hospital Augusta, Georgia 30904
Hughes, Joe L., M.D. Active—Fulton	1311 Cleveland Avenue East Point, Georgia 30044
Hyers, John J., M.D. Active—Fulton	2285 Peachtree Rd., N.E. Atlanta, Georgia 30309
Machado, Mario, M.D. Active—Fulton	2718-B Felton Drive East Point, Georgia 30044
Marks, Thomas W., M.D. Active—Fulton	340 Boulevard, N.E. Atlanta, Georgia 30312
Mastrianni, D. T., M.D. Active—Muscogee	Medical Center Columbus, Georgia 31902
Naib, Z. M., M.D. Active—Fulton	80 Butler Street, S.E. Atlanta, Georgia 30303
Newton, John S., M.D. DE-2—Richmond	Medical College of Georgia Augusta, Georgia 30902
Paar, John A., M.D. Active—Richmond	Talmadge Memorial Hospital Augusta, Georgia 30902
Pilcher, B. Lamar, M.D. Active—Peach Belt	Houston County Hospital Warner Robins, Georgia 31093
Playford, George A., M.D. Active—Richmond	Medical College of Georgia Augusta, Georgia 30902
Prater, R. Burt, Jr., M.D. DE-4—DeKalb	1600 Clifton Road, N.E. Atlanta, Georgia 30333
Severs, Ronald G., M.D. Active—Peach Belt	1606 Watson Boulevard Warner Robins, Georgia 31093
Smith, J. Graham, M.D. Active—Richmond	Medical College of Georgia Augusta, Georgia 30902
Steves, Severo, M.D. Active—Fulton	3136 Barkside Court Chamblee, Georgia 30005
Turcotte, Maurice R., M.D. Active—Fulton	2748-A Felton Drive East Point, Georgia 30044
Vickery, S. A., M.D. Active—Jackson-Banks	Medical Center Clinic Commerce, Georgia 30529
Walker, James A., M.D. DE-2—DeKalb	2349 Sanford Road Decatur, Georgia 30033
Ward, Charles J., M.D. DE-4—DeKalb	193 Dabney Place Newport News, Virginia 23602

SOCIETIES

The members of the **Sixth District Medical Society** and their wives will meet Wednesday evening, April 17, in Thomaston at the Hotel Upson. A social hour will be followed by dinner. Comptroller General James L. Bentley will be the speaker. This is an opportunity for us to be with our colleagues in the newly joined Sixth District.

Curtis Hames, President of the **Bulloch-Candler-Evans Medical Society,** presented the scientific program for the February meeting of the society. It consisted of a movie and group discussion of the use of the drug Clofibrate in the treatment of hypercholesterolemia and hypertriglyceridemia.

The members of the **Wilkes County Medical Society** heard George F. Armstrong of Atlanta speak at their February meeting. Dr. Armstrong is a pediatric cardiologist.

The **Peach Belt Medical Society** met February 20 at the Houston Lake Country Club. Dr. John O'Shaughnessey gave a program on nasal allergies.

The **Tift County Medical Society** has elected Tom Edmondson president with Robley Smith as vice president and Paul Lucas secretary-treasurer.

PERSONALS

Second District

Henry Gordon Davis, Jr., of Sylvester has been reelected to active membership in the American Academy of General Practice, as has **Henry Alford Bridges** of Bainbridge.

A letter to the editor of the Camilla *Enterprise* praised **Laurier Eugene Hackette** for stopping to give aid to the victim of an automobile accident, carrying him to the hospital and staying with him until his own physician was called.

Third District

Jack C. Hughston of Columbus has been reappointed a member of the Committee on Medical Aspects of Sports of the American Medical Association.

Fourth District

Lawrence L. Allen, Jr., and **Thomas A. Sappington** of Thomaston have been reelected to the American Academy of General Practice.

Earnest C. Atkins, chief of staff of DeKalb General Hospital, presided at a breakfast given by the medical staff of the hospital in honor of the DeKalb County Commissioners, in appreciation of the cooperation the Commission has given toward financing a proposed expansion of the hospital.

Fifth District

Bruce Logue of Atlanta recently conducted grand rounds at Duke University and participated in the program of the Watts Hospital Symposium.

James H. Litton of Tucker has been reelected to active membership in the American Academy of General Practice.

Fred L. Allman, Jr., of Atlanta has been reappointed a member of the Committee on Exercise and Physical Fitness of the American Medical Association and **J. Frank Walker** of Atlanta has been reappointed to the Council on Legislative Activities.

Former residents in surgery at Emory University have set up a $4,000 lectureship fund in honor of one of their professors, **J. C. Thoroughman,** who is chief of surgery at the Atlanta Veterans Hospital and professor of surgery at Emory.

Seventh District

F. W. Morgan and **Claude V. VanSant, Jr.,** of Douglasville have been reelected to active membership in the American Academy of General Practice as have **Charles Hadley Allen** of Bremen and **Robert Daniel Walter** of Calhoun.

Eighth District

Richard K. Winston of Valdosta has been nominated by the hospital authority for the distinguished service award for citizen of the year. The Georgia Hospital Association will make the selection later in the spring.

DEATHS

Clara B. Barrett

Clara B. Barrett, retired director of the tuberculosis division of the State Department of Health, died February 1, 1968, at her home in Atlanta.

Dr. Barrett was a graduate of Shorter College. She received her medical degree at Tulane University, interned in Memphis and served her residency in Chicago. Dr. Barrett spent two years at Macon Hospital and then joined the State Health Department in 1928. She joined the tuberculosis division in 1930 and was made director in 1956.

Named Woman of the Year in Medicine in 1958 by the American Medical Women's Association, Dr. Barrett retired in 1960. She was a member of the Fulton County Medical Society and the Medical Association of Georgia. She was a member of the Cathedral of St. Philip.

Surviving is a sister, Mrs. Edward L. Kemper of Shelby, North Carolina.

Gregory W. Bateman

Gregory W. Bateman, an Atlanta physician for 25 years, died February 29, 1968, in a private hospital.

Dr. Bateman was graduated from Emory University and the Medical College of Georgia. He was a member of Delta Tau Delta fraternity and Theta Kappa Psi medical fraternity.

Active in the Republican party, Dr. Bateman had served on the State Central Committee. He was a member of the Fulton County Medical Society, the Medical Association of Georgia and the American Medical Association. Dr. Bateman was a member of the Baptist church.

Survivors include his wife, the fromer Anne Chambless; a son, Needham B. Bateman, III; two daughters, Miss Susan Ellen Bateman and Miss Elizabeth Bateman, both of Atlanta; his mother, Mrs. Maude B. Avant, Deepstep; a sister, Mrs. Troy Edwards, Eatonton; and two brothers, Dr. Needham Bateman of Jonesboro and Dr. Osgood Bateman of Sandersville.

C. W. Dyer

C. W. Dyer of Macon, founder of St. Luke's Hospital there, died February 15, 1968, at his home.

Dr. Dyer was a native of the West Indies. He attended Meharry Medical College in Nashville, Tennessee, and did further work at Howard University.

Dr. Dyer was on the staff of Macon Hospital and once served as an officer of the National Medical Association. He was a past president of the Macon Academy of Medicine. Dr. Dyer was a member of the Medical Association of Georgia. He had been retired for some time due to ill health.

He is survived by his wife and one daughter, Mrs. Estizer Anderson.

Richard C. Hackney

Richard C. Hackney, 56, an Atlanta physician and surgeon, died February 7, 1968, in McLendon Hospital.

Dr. Hackney graduated from Morehouse College and received his medical degree from Meharry Medical College. He served his internship in St. Louis at the Homer

G. Phillips Hospital and was a staff member there for five years.

Dr. Hackney was a member of the Atlanta Medical Society, the Fulton County Medical Society and the Medical Association of Georgia. He was a member of St. Paul of the Cross Catholic Church, the St. Paul of the Cross School board and the Knights of Columbus. He was also a lifetime member of the National Association for the Advancement of Colored People.

Dr. Hackney received one of the first two Alumni Medals for outstanding achievement from Morehouse College.

Survivors include his wife, the former Gertrude Pruitte, and four sons, Richard, Wendell, Elbert and Forrest Hackney, all of Atlanta.

John Jacob Westermann, Jr.

John Jacob Westermann, Jr., 77, died at his residence on Sea Island February 7, 1968, after a short illness. He had resided at Sea Island for the past 13 years.

Dr. Westermann had been a surgeon at St. Luke's Hospital in New York for 40 years and was one of the founders group of Diplomates of the American Board of Surgery. He was a member of the New York Surgical Society, the American Medical Association, the Medical Association of Georgia and a member of St. Simons Island Presbyterian Church.

Survivors include his wife, Mrs. Blanche White Westermann; one daughter, Mrs. John Castronuovo, Glen Rock, New Jersey; one son, David Westermann of Huntington Station, New York; and one step-daughter, Mrs. Barbara Dempsey of Puerto Rico.

Otis Clark Woods

Otis Clark Woods, 65, Milledgeville physician and surgeon, died March 2, 1968.

A graduate of the University of Georgia, Dr. Woods received his medical degree from the Medical College of Georgia. He was a fellow of the American College of Surgeons and a member of the Medical Association of Georgia. He was also a member of the First Presbyterian Church.

Dr. Woods was a former president of the board of trustees of Georgia Military College and was chairman of the board from 1956 to 1967.

Surviving are his wife, the former Otelia Flemmister; sons, Otis C. Woods, Jr., of Atlanta, and Lewis Woods of San Francisco; his stepmother, Mrs. S. A. Woods of Kite; sisters, Mrs. W. B. Meeks, Mrs. J. H. Wheeler and Mrs. Virgil Wheeler, and a brother, Sam A. Woods, Jr., all of Kite.

TRAUMA AND DISEASE INVOLVING CHILDREN TO BE TOPIC OF ORTHOPAEDICS MEETING

The Fifth Atlanta Post-Graduate Course, sponsored by the Committee on Injuries of the American Academy of Orthopaedic Surgeons in conjunction with the Scottish Rite Hospital for Crippled Children in Decatur, will be held April 25 through 28 at the Marriott Hotel in Atlanta.

Entitled "Current Concepts on Management of Trauma and Disease Involving Children," the course is under the direction of Wood W. Lovell, M.D., Surgeon-in-Chief at the Scottish Rite Hospital. The outstanding guest faculty includes eighteen orthopaedic surgeons from across the United States, Canada and Hong Kong.

The course is designed for general surgeons, orthopaedic surgeons and general physicians. It has been approved for 30 hours of credit by the American Academy of General Practice. There is a registration fee of $100 which includes three luncheons and the Chairman's Reception. Residents and interns may register free of charge when accompanied by a letter from their chief of service. There will be a $10 fee for the luncheons and reception.

PFIZER LABORATORIES SCHOLARSHIP PROGRAM

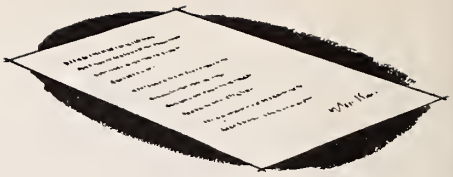
The Medical Department of Pfizer Laboratories Division has announced that it will make available $1,000 medical school scholarships to each of the country's 98 medical schools, bringing to $640,000 the total contributed since the program was launched in 1962.

Selection of the recipient of the scholarship may be on the basis of scholastic record, financial need or both. The scholarships are designed primarily to apply toward academic and subsistence expenses of one student in each of the medical schools in the United States. The scholarships are administered solely by the dean of each medical school, or by a committee established by him.

Since their inception in 1962, the Pfizer scholarships have been accepted in each of the medical schools in the United States.

In addition to the medical school scholarship program, Pfizer has also provided the American Medical Association's Educational and Research Foundation with $450,000 in the past six years. These Pfizer grants have provided $5,625,000 credit for loans to medical students, interns and residents during this period. Recipients of the loans are in training in more than 660 medical schools and hospitals throughout the country.

ABSTRACTS BY GEORGIA AUTHORS



Croswell, Hal H., Jr., M.D., and Haldi, Mrs. Betty Anne, Emory University School of Medicine and Grady Memorial Eye Clinic, Atlanta, Ga., "The Superior Oblique Tendon Sheath Syndrome. A Report of Two Bilateral Cases," Journal of Pediatric Ophthalmology 4:8-12(Nov.)1967.

Two cases representing a bilateral superior oblique tendon sheath syndrome were reported. The literature was reviewed with specific regard to incidence of this condition in a bilateral form and management. Both cases were followed for a significant period of time without change in the syndrome. Surgical treatment was not recommended in either case because of the presence of fusion in both primary and reading positions and the absence of any deforming head tilt.

Chennault, Madelyn E., Ed.D., Atlanta University, Atlanta, Ga., "Improving the Social Acceptance of Unpopular Educable Mentally Retarded Pupils in Special Classes," Am. J. Mental Deficiency 72:455-458(Nov.) 1967.

Subjects for the study were 64 unpopular children in 16 special classes (Negro, IQ 50-79, CA 10-16). In eight of the classes, attempts were made to improve the peer acceptance of two of the four least popular pupils through organized cooperative group activities. Results showed significant improvement in peer acceptance and self-perceived peer acceptance for the experimental subjects. These gains were significantly larger than gains for control subjects "within" the same class. The "inside" control subjects did not differ significantly from "outside" control subjects.

Dowdle, Walter R., Ph.D.; Nahmias, Andre J., M.D.; Harwell, Rebecca W., B.S.; and Pauls, Frank P., Dr.P.H., National Communicable Disease Center and Emory University School of Medicine, Atlanta, Ga., "Association of Antigenic Type of Herpesvirus Hominis With Site of Viral Recovery," Journal of Immunology 99:974-980 (Nov.)1967.

Ninety-one *Herpesvirus hominis* strains isolated from a variety of sites representing various clinical manifestations were tested by the micro quantal neutralization technique against antisera determined previously to represent two antigenic types of herpesvirus. The virus isolates could be divided into two distinct groups each with a distribution similar to that of a control virus representing type 1 or type 2. All 42 strains identified as type 2 were isolated from herpetic infections related directly or indirectly to involvement of the adult genital tract. The remaining 49 strains, identified as type 1, represented all other sites and included viruses associated with meningoencephalitis, eczema herpeticum, dermatitis (other than on thigh and buttocks), gingivostomatitis, asymptomatic herpes, and herpes labialis. The association of a particular antigenic type of herpesvirus to the genital tract, or closely related sites, is of particular biological and epidemiological interest and suggests a specific tropism of a virus type.

Kagan, Irving G., Ph.D.; Fox, Howard A., M.D.; Walls, Kenneth W., Ph.D.; and Healy, George R., Ph.D., National Communicable Disease Center, Atlanta, Ga.: "The Parasitic Diseases of Childhood, With Emphasis on the Newer Diagnostic Methods," Clinical Pediatrics 6:641-654(Nov.) 1967.

A summary of several important parasitic infections encountered in children is presented. Good diagnostic methods and excellent therapy are available for some infections. The importance of early recognition of amebiasis in children is stressed, and the availability of new serologic tests which are very specific and sensitive for extraintestinal involvement was reviewed. New developments in the serologic diagnosis of toxoplasmosis were also reviewed. There is a discussion of the visceral larva migrans syndrome and the absence of adequate therapy and specific serologic diagnosis was noted. A complete review is given of the status of infection with *Pneumocystis carinii* which includes advances in treatment and recognition of this infection in children.

Rhode, C. Martin, M.D., and Jennings, W. D., Jr., M.D., Veterans Administration Hospital and Medical College of Georgia, Augusta, Ga., "Dupuytren's Contracture," American Surgeon 33:855-877(Nov.)1967.

Our surgical treatment of more than fifty hands with this deformity is presented. In our earlier experience, radical excision of the palmar fascia was performed with moderate success. The complications with this procedure were significantly high and included delayed wound healing, prolonged recovery and some limitation of useful motion.

During the last six years we have altered our surgical approach; now performing partial excision of the fascia, limited to the hyperthrophied, pathologic portion actually causing the flexion contracture of the finger or fingers. Under these circumstances, our results have been far superior and postoperative complications few.

After the initial postoperative period of immobilization, restoration of normal function of the fingers is our goal. Dynamic splinting is of critical importance during this phase of therapy.

Patients with advanced contracture will have one or more fingers rigidly flexed into the palm. These patients initially require a limited palmar fasciotomy followed by dynamic splinting to partially oblate the deformity. The remaining finger contracture is then corrected by limited excision, only of the involved fascia causing the deformity. Finally, a volar capsulotomy of the proximal interphalangeal joint may be required to obtain full active and passive extension of the finger.

Fletcher, Gerald F., M.D., Hurst, J. Willis, M.D., and Schlant, Robert C., M.D., Emory University School of Medicine and Grady Memorial Hospital, Atlanta, Ga., "Electrocardiographic Changes in Severe Hypokalemia, A Reappraisal," American Journal of Cardiology 20:628-631 (Nov.)1967.

A number of studies in the medical literature of the last two decades describe the electrocardiographic changes associated with hypokalemia. Because of the indefinite conclusions of certain investigators regarding these changes in severe hypokalemia, the following observations and subsequent reports were made.

For a period of six months the daily serum electrolyte determinations were checked in the clinical laboratory. All in-patients with serum potassium of 2.5 mEq/L or less had electrocardiograms taken in close approximation of the time blood was taken for serum potassium determination. Follow-up electrocardiograms were taken until correction of the hypokalemia or until death. Note was made of the patient's diagnosis and amount and method of potassium replacement.

Of twenty-four patients with serum potassium of 2.5 mEq/L or less, five (20.8 per cent) had severe, classical (Q-T, S-T and U segment) electrocardiographic changes of hypokalemia, sixteen (66.7 per cent) had mild-moderate changes while only three (12.5 per cent) had no abnormalities. It is noteworthy that eleven of the twenty-four were alcoholic cirrhotics and six of the twenty-four died. Only one of the group of twenty-four had known heart disease. No correlation between serum carbon dioxide content and electrocardiographic changes was apparent.

Although most (87.5 per cent) of these patients with severe hypokalemia (serum potassium 1.6-2.5 mEq/L) had at least some abnormalities on the electrocardiogram, there was no correlation between the severity of these changes and the severity of the hypokalemia below 2.5 mEq/L.

Hamilton, John W., Ph.D., and Stephens, Lynn Y., B.A., Gracewood State School and Hospital, Gracewood, Ga., "Reinstating Speech in an Emotionally Disturbed, Mentally Retarded Young Woman," Journal of Speech and Hearing Disorders 32: 383-389(Nov.)1967.

This report dealt with the reinstatement of speech in a mentally retarded, emotionally disturbed, institutionalized woman who had a history of speech behavior, but who had not spoken in the hospital setting since her admission five years before. The behavior problems of floor-rolling and screaming were brought under control prior to speech training by a program of confinement to a time-out area for thirty minutes whenever either of these behaviors occurred. The first phase of speech training involved eliciting verbal behavior with cookie rewards by one experimenter in a private room. The next phase involved generalizing this speech behavior to the ward setting. The method used was the operant conditioning procedure of reinforcing speech behavior by fulfilling only those requests which were made verbally. In addition to the rapid development of speech behavior on the ward, the patient made substantial gains in general social behavior.

Lischner, Mark W., M.D., MacNabb, George M., M.D., and Galambos, John T., M.D., Grady Memorial Hospital and Emory University School of Medicine, Atlanta, Ga., "Fatal Hepatic Necrosis Following Surgery," Archives of Internal Medicine 120: 725-728(Dec.)1967.

A case of fatal hepatic necrosis following surgery and the administration of methoxyflurane (Penthrane) is presented. It is compared with three similar cases found in the English literature. The outstanding features were a striking eosinophilia, a vesicular rash and the temporal relationship of the anesthesia. Problem of distinguishing viral from drug induced hepatitis is re-emphasized.

Folger, Gordon M., Jr., Medical College of Ga., Augusta, Ga., "Tetralogy of Fallot in Twins," Southern Medical Journal 61:64-67(January) 1968.

Concordant cardiovascular anomalies occurring in twins are uncommon with only 19 documented instances reported, including the subject of this report. Of these, eight cases are of patent ductus arteriosus, the remainder being intracardiac malformations. The subject of this report is two male twin siblings considered to be monozygous in whom a congenital cardiac defect identified as the tetralogy of Fallot was discovered. This malformation has been reported in twins in only one other instance.

Farrar, W. Edmund, Jr., M.D., and Dekle, Lawrence C., A.B., Emory Univ. School of Medicine, Atlanta, Ga., "Transferable Antibiotic Resistance Associated With an Outbreak of Shigellosis," Annals of Internal Medicine 67:1208-1215(Dec.)1967.

An outbreak of dysentery due to *Shigella flexneri* 2a involving 14 individuals in four households (10 in one household) was investigated. Six of the 14 individuals were found to be excreting shigellae resistant to multiple antimicrobial agents (ampicillin, streptomycin, tetracycline, chloramphenicol, and sulfisoxazole) whereas nine were excreting organisms sensitive to all antibiotics tested. The suspected episomal nature of the multiple antibiotic resistance was confirmed by *in vitro* transfer of this property to an antibiotic-sensitive strain of *Escherichia coli*. With one exception, only fully sensitive or multiply-resistant organisms were found in the stools of a given individual, but only a few colonies from each culture were picked for study. A three-year-old male who became ill early in the course of the outbreak was found to be excreting both sensitive and resistant organisms. It is postulated that antibiotic resistance was acquired by *Shigella* from coliform organisms present within his gastrointestinal tract and that he served as a source for both sensitive and resistant organisms. This is the first demonstration in the United States of transferable antibiotic resistance occurring in association with an outbreak of shigellosis. The occurrence of *Shigella* resistant to many antibiotics including ampicillin, the current drug of choice, has important implications for the future management of infections due to these organisms.

Smith, Richard S., M.D., Washington, D.C., Maddox, Fleetwood, M.D., and Collins, Braswell E., M.D., Macon, Ga., "Congenital Alacrima," Archives of Ophthalmology 79:45-48 (Jan.)1968.

Deficient lacrimal secretion occurs more commonly in adults than in children and is known as Sjögren's syndrome. Alacrima as a congenital defect is distinctly unusual and only 14 cases have been reported in the literature up to 1952. This case is unique in that it occurred unilaterally in a 10-year-old Negro boy. The unusual findings are epidermalization of the corneal epithelium and corneal vascularization. This condition may result from the following: 1) Persistence of neonatal alacrima; 2) Neurologic defects; 3) Hypoplasia of the lacrimal gland; 4) Riley-Day syndrome; and 5) Anhidrotic ectodermal dysplasia. The condition in the case presented is best explained as resulting from a unilateral persistence of neonatal alacrima.

Lewis, M., B.A., Chown, B., M.D., Kaita, H., Hahn, D., M.D., Kangelos, M., M.S., Shepeard, W. L., M.D., and Shackelton, K., B.S., Department of Pediatrics, University of Manitoba and Rh Laboratory, Winnipeg, Canada, Departments of Pediatrics and Pathology, Medical College of Georgia and Eugene Talmadge Memorial Hospital, Augusta, Ga., and Kansas City University Medical School, Kansas City, Kansas, "Blood Group Antigen Go^a and the Rh System," Transfusion 7:440-441(Nov.-Dec.)1967.

Our group in Georgia investigated two negro female propositae, Holl and Wigg, Rho (D) positive who had produced Rho (D) antibodies. It is evident that these two individuals may have genes the same as one of the Rh variant genes (A, B, C, D) of Unger and Wiener.

Comparative studies of the sera and cells from these two propositae and their families made by Marion Lewis, Dr. Bruce Chown and Marilyn Kangelos with Go^a anti sera furnished by Dr. Aaron A. Alter and Mr. David Hatcher and other cells and sera from Dr. Sturgeon indicates the Go^a is probably an Rh antigen.

Our data agrees with those of Lovett and Crawford in placing Go^a in the Rh system.

Evans, George H., M.D., and Scardino, Peter L., M.D., Memorial Hospital of Chatham County, Savannah, Georgia, "Drip Infusion Pyelography," Southern Medical Journal 60: 1297-1302(Dec.)1967.

The technique of Drip Infusion Pyelography was popularized by Schenecker in 1964. Its use is now widespread throughout the country and has been used in our hospital in over 500 cases. The technique has provided a method of improvement of visualization of the upper urinary tract and the bladder. The routine use of this technique would be prohibitively expensive, but in indicated cases the visualization has been much superior to single dose Pyelography. This technique has reduced the number of retrogrades performed in our hospital by some 31 per cent.

Nader, Philip R., M.D., Horwitz, Marshall S., M.D., and Rousseau, John, M.D., National Communicable Disease Center, Atlanta, Georgia, and Riverton, Wyoming, "Atypical Exanthem Following Exposure to Natural Measles: Eleven Cases in Children Previously Inoculated With Killed Vaccine," J. Pediatrics 72: 22-28(Jan.)1968.

A severe illness with an atypical exanthem occurred in the spring of 1966 in Riverton, Wyoming, during a period of increased incidence of measles. The cases in children, aged 5-11 years, were characterized by high fever, tachypnea, myalgia, and prostration. A maculovesicular rash characteristically began on the lower extremities. Laboratory and epidemiologic data were highly suggestive of recent unrecognized and atypical natural measles infection. A study of the group of 97 children who had four years previously received inactivated measles vaccine showed that no cases of measles occurred among the 31 children who subsequently received live vaccine; however, six per cent of these children had local reactions at the site of injection of live vaccine. Those children are compared with 66 children who were not given subsequent live vaccine, 17 per cent of whom manifested a severe atypical illness following exposure to natural measles.

Murphy, Frederick A., D.V.M., and Fields, Bernard N., M.D., National Communicable Disease Center, Atlanta, Ga., "Kern Canyon Virus: Electron Microscopic and Immunological Studies," Virology 33:625-637(Dec.)1967.

Kern Canyon virus (KCV), propagated in suckling mouse brain and cell culture, was examined by negative contrast and thin section electron microscopy. The virus was found to exhibit symmetry similar to other viruses of the Stomatoviridae family. The bullet-shaped virus particles had a mean length of 132 mμ and were 73 mμ in diameter. Cross striations, axial channels and surface projections were prominent. Virus maturation occurred on marginal cytoplasmic membranes with mature virions accumulating extracellularly. Complement fixation, virus neutralization, and immunodiffusion tests comparing KCV with other bullet-shaped viruses of animals confirmed the distinct antigenicity of the virus, whereas comparison of KCV with vesicular stomatitis virus in a density gradient ultracentrifugation experiment emphasized the physical basis for including KCV within the Stomatoviridae family of viruses.

Tait, C. Downing, Jr., M.D., Emory University School of Medicine, Atlanta, Ga., "A 'Therapeutic Community' for Selected Families: New Approach to Juvenile Delinquency?," Mental Hygiene 52:45-49(January) 1968.

This paper describes a "family therapeutic community," proposed to help prevent juvenile delinquency. This new resource would be analogous to residential treatment for the individual; it would be a "family hospital." In practical terms, a special staff would be assigned to a designated public housing project with authorization to study and foster the kind of home and neighborhood environment that would be more "therapeutic" for selected multi-problem resident families with one or more potentially delinquent children.

The project staff would represent various professional disciplines and community agencies serving or studying children and families. With offices in one building of the housing project where the families reside, this staff would have the benefit of daily on-the-spot observations to guide its efforts to understand families, to stimulate better solutions to individual and family problems, and to promote more satisfactory living conditions so that fewer problems would arise. A plan somewhat similar has been tried in Holland, and suggested by two other Americans—Shipman and Martin.

The author suggests setting up a family therapeutic community as a pilot project in the U.S. He is hopeful it might even become a "couch" or "workbench" for studying delinquency.

Shotts, Emmett B., Jr., Ph.D., Foster, John W., Ph.D., Brugh, Max, D.V.M., Jordan, Helene, Ph.D., and McQueen, James L., Dr.Ph., School of Veterinary Medicine, University of Georgia, Athens, Ga., and National Communicable Disease Center, Atlanta, Ga., "An Intestinal Threadworm as a Reservoir and Intermediate Host for Swine Influenza Virus," J. Experimental Medicine, 127:359-369(February 1)1968.

A laboratory model exemplifying Shope's concept of virus carriage by helminths was developed using *Strongyloides ratti* (Sandground, 1925), swine influenza virus, and caesarean-originated, barrier-sustained (COBS) mice and rats.

It was shown that *S. ratti* can act as a carrier of swine influenza virus and infect mice, despite the fact that the nematode has undergone a complete life cycle after exposure to virus in infected rats.

It is suggested that this laboratory model be used to study more closely the various aspects of the ecology of virus-helminth relationships in vertebrate hosts.

Folger, Gordon M., Jr., M.D., Medical College of Georgia, Augusta, Ga., "Supravalvular Tricuspid Stenosis," Am. J. Cardiology, 21:81-87(January)1968.

This report is concerned with two patients with cyanotic congenital cardiac malformations who were found to have supravalvular tricuspid obstruction. This malformation and the constellation of defects associated with it: underdevelopment of the right ventricle and abnormalities involving the pulmonary valve and derivatives of the sixth aortic arch, constitutes a distinct anatomic entity which has received little recognition. The primary anomaly is likely the result of persistence of significant portions of the valves of the sinus venosus with resultant membranous obstruction of the tricuspid orifice. The other associated right heart defects may represent the effect of the pretricuspid shunting on the developing heart.

These two cases of this unusual malformation have been studied clinically and at autopsy. In each case, a diaphragm of dense connective tissue arising from the rims of the coronary sinus and inferior vena caval orifices, the atrial wall and interatrial septum, produced severe obstruction of the tricuspid orifice. Associated malformations included pulmonary valvular atresia with intact ventricular septum in one case and supravalvular stenosis just distal to the pulmonary valve in the other. Patent ductus arteriosus was present in both and pulmonary valvular and arterial malformations occurred as additional abnormalities in the case with supravalvular pulmonic stenosis.

Gangarosa, Eugene J., M.D., Bisno, Alan L., M.D., Eicher, Edward R., M.D., Treger, Michael D., D.V.M., Goldfield, Martin, M.D., DeWitt, Wallis E., M.S., M.P.H., Fodor, Tibor, M.D., M.P.H., Fish, Sylvan M., M.D., Dougherty, William J., M.D., Murphy, John B., M.D., Feldman, John, B.A., and Vogel, Henry, Ph.D., National Communicable Disease Center, Atlanta, Ga., New Jersey State Department of Health, Trenton, N. J., New York City Department of Health, Philadelphia Department of Public Health, Philadelphia, Pa., Department of National Health and Welfare, Ottawa, Canada, and Food and Drug Administration, New York District, N. Y., N. Y., "Epidemic of Febrile Gastroenteritis Due to Salmonella Java Traced to Smoked Whitefish," Am. J. Public Health, 58:114-121(January)1968.

During the 1966 Memorial Day weekend there were more than 12 separate outbreaks with 300 or more cases of febrile gastroenteritis due to *Salmonella java* in the metropolitan areas of New York, Pennsylvania, and New Jersey. This was a single-wave, common-source epidemic; the vehicle was whitefish smoked in a plant in Brooklyn. The infecting organism was isolated from the stool of patients, from whitefish ingested by these patients, from 11 employees of the plant where the fish was processed, and from three shipments of raw unprocessed fish in storage. The source of contamination of whitefish was traced to the Great Slave Lake, Northwest Territory, Canada. The cause of contamination was probably the practice of using raw river water to wash dressed fish and to make ice to pack them in. A combination of circumstances that favored the growth and proliferation of salmonellae in contaminated fish at the Brooklyn processing plant probably caused the epidemic. It is possible that similar epidemics in 1934, 1940, and 1955 in the metropolitan areas of New York, New Jersey, and Pennsylvania were similar to the epidemic reported here with respect to the source and fortuitous circumstances permitting proliferation of contaminating salmonellae in whitefish.

Stovall, Russell, M.D., and Jackson, R. T., Ph.D., Emory University School of Medicine, Atlanta, Ga., "Prostaglandins and Nasal Blood Flow," Annals of Otology, Rhinology and Laryngology 76:1051-1059(December)1967.

A rhinometric technique was used to measure the changes in the blood flow in the dog's nasal mucosa. Four forms of prostaglandin (PGE_1, PGA_2 and $PGF_{1\alpha}$) were compared to epinephrine, norepinephrine and papaverine. The drugs were introduced into the carotid artery in pentobarbital-anesthetized dogs. All the PG's induced a constriction of the blood vessels of the nasal mucosa. The two PGE forms were equipotent to epinephrine but their duration of action was more than seven times as long. The response to PG seemed to have little effect on subsequent responses to epinephrine. Also, the response to PG seemed little affected by prior treatment with vasodilators such as papaverine or aminophylline. The threshold dose of PGE was near 1x10-6 mg/kg; within the limits of sensitivity to PGE in other preparations. Commonly, the lower doses of PGE induced a nasal response without a corresponding change in blood pressure.

Nahmias, André J., M.D., Froeschle, James E., M.D., Feorino, Paul M., Ph.D., and McCord, George, M.D., Emory University School of Medicine and Grady Memorial Hospital, and the National Communicable Disease Center, Atlanta, Ga., "Generalized Eruption in a Child With Eczema Due to Coxsackievirus A16," Archives of Dermatology 97:147-148 (February)1968.

A 1-year-old infant with preexisting atopic eczema who developed a generalized vesicular exanthem resembling Kaposi's varicelliform eruption was studied. Virological, serological and cytological studies were compatible with a coxsackievirus A16 infection, while no evidence of infection with herpes simplex, vaccinia, or varicella viruses could be obtained. The term eczema coxsackium is proposed and the suggestion is made to search for other viral agents that may affect eczematous or other dermatological conditions.

Nandy, Kalidas, M.D., Emory U. School of Medicine, Atlanta, Ga., "Further Studies on the Effects of Centrophenoxine on the Lipofuscin Pigment in the Neurons of Senile Guinea Pigs," J. Gerontology 23:82-92(January)1968.

The most regular cytological change correlated with aging is the accumulation of a type of pigment of lipid origin commonly known as lipofuscin. Centrophenoxine is a new chemical substance synthesized from an aminoalcohol and p-chlorophenoxyacetic acid. It is a metabolic regulator influencing cellular respiration and glucidic metabolism in the vegetable cell.

The effects of Centrophenoxine on the lipofuscin pigments have been studied by a number of histochemical methods. The pigments accumulated steadily in the neurons of CNS in guinea pigs with the increase of age and a marked reduction was observed in the pigments after treatment by the drug for ten weeks or more.

The drug also reduced the activity of succinic and lactic dehydrogenases and cytochrome oxidase and enhanced that of glucose-6-phosphate dehydrogenase. It has been suggested that the drug may help to eliminate the old age pigments by a possible diversion of the glucose metabolism via pentose cycle. The reduction of simple esterase and acid phosphatase may be due to the effect of the drug on the lysosomes which are intimately related to the genesis of these pigments.

Vogler, William R., M.D., Furtado, Valdir P., M.D., and Huguley, Charles M., Jr., M.D., Emory U. School of Medicine, Atlanta, Ga. "Methotrexate for Advanced Cancer of the Breast," Cancer 21:26-30 (January)1968.

Forty-one patients with progressive metastatic breast cancer were treated with methotrexate in divided daily doses of 1.25 to 2.5 mg every six hours for five days. Courses were repeated at intervals of 14 to 28 days. Except for two patients, all had relapsed or failed to respond to corticosteroids, androgens or estrogens. In the remaining two patients, one had failed to respond to castration and the other refused hormone therapy. Skeletal metastases were present in 35 patients. Four showed only visceral involvement, and two had only chest wall recurrence. In 28 patients methotrexate was the only treatment given. In the remaining patients androgens or corticosteroids were continued during methotrexate therapy.

Eight patients were inadequate trials because they received less than three courses of methotrexate. Six died within the first month of treatment and two were lost to follow-up after only one course of treatment. Of 33 patients who received a minimum of three courses of methotrexate, six obtained a good response, that is regression in measurable disease by more than 50 per cent; four had a fair response, that is 20 per cent regression in measurable disease; and five had less than 20 per cent regression of measurable disease. Eleven other patients showed a subjective improvement consisting of a decrease in analgesic requirements and an increase in performance status. Only seven patients failed to show any response. The duration of response averaged nine months. There was no significant difference in those treated with methotrexate only and those receiving methotrexate plus hormones. These findings indicate that methotrexate given in a clinically practical way will produce a high percentage of responses in women with advanced breast cancer, without undue toxicity.

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THE AMA JUNE CONVENTION—"KEEPING UP"

The 117th Annual Convention of the AMA will be held June 16-20 this year in San Francisco. The Civic Auditorium, War Memorial Opera House, and several nearby hotels will house the scientific program; the House of Delegates will meet in the Fairmont Hotel.

Approximately 600 scientific papers are to be presented, and more than 250 scientific exhibits will be on display as well as many industrial exhibits.

Among special presentations planned are four General Scientific Meetings on automobile accidents, health care planning, management of infectious diseases, and treatment of advanced malignant disease.

Four General Scientific Sessions will be presented and the 23 Scientific Sections will offer programs individually, many holding joint meetings on subjects of common interest.

A full schedule of medical motion pictures is planned, as is a program of live color telecasting from a San Francisco-area medical center.

Demands placed upon the American health care system have made the health services industry the nation's fastest growing employment field, American Medical Association president Milford O. Rouse, M.D., pointed out in a year-end report.

"Fifteen years ago it was the fifth largest employer, now it is third," said Dr. Rouse. "If present trends continue, it will become the nation's No. 1 employer by the early 1970's."

Few physicians need instruction in the facts concerning increased demand. In addition to the growing claims upon him by patients, medical society, hospital, civic affairs and family, the physician faces his responsibility to himself to "keep up" with medical developments.

Once a year, the physician has an opportunity to spend the better part of a week doing nothing but "keeping up" at the world's largest medical meeting, the Annual Convention of the American Medical Association.

DEXTRAN SYMPOSIUM TO BE HELD IN TEXAS

The first International Symposium on Dextrans will be held at Galveston Island, Texas, on Sunday and Monday, May 19 and 20, 1968. Entitled "Current Concepts of the Basic Actions of Dextrans and Their Clinical Application in the Cardiovascular and Related Fields," the symposium is co-sponsored by the Texas Heart Association, the Council on Circulation of the American Heart Association, the Postgraduate Education Division of the University of Texas Medical Branch, the University of Minnesota Medical School and the Georgia Institute of Technology—Biomedical Division.

Researchers from Europe and the United States who have carried out extensive research studies on the Dextrans for 20 years or more will participate in this important two-day symposium. Program planners advise that the major emphasis of the symposium will be placed on the use of Dextrans in the cardiovascular field.

Programs, advance registration, and hotel reservation forms for the Dextran Symposium may be obtained by writing the Texas Heart Association, P.O. Box 25041, Houston, Texas 77005.

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ACRANIAL MONSTER: SPECIMEN AND REPORT OF THE CASE

By W. P. WILLIAMS, M.D., Blackshear, Ga.

The case and specimen which I present to the Association may be more readily understood by a brief clinical history. Mrs. H. R., multipara, aged twenty-three, had had two normal and uneventful pregnancies, giving birth to normal and well-developed children, one of which lives, a fine specimen of healthful and vigorous childhood. Her last menstruation occurred on March 27, 1896. About the last of April nausea and vomiting from her pregnancy set in, and continued with unusual severity for about three months. In July she suffered a severe fright from a snake. On November 1st her home was burned at two o'clock in the morning, she being the first to discover the fire, which had gained such headway that the family barely escaped with their lives.

At four and a half months from date of last menstruation she detected the fetal movements, this occurring in first part of August. The movements continued lively until about Christmas and first of January, which should have been her normal term (about January 3d being the term from common methods of calculation.)

From this time fetal movements became less active until they almost ceased until the day before delivery, when they again became unusually lively. In December she experienced a very severe attack of dysentery lasting about two weeks, leaving her in a very debilitated state.

On the morning of March 10, 1897, labor came on, and when I arrived I found on examination a normal face presentation with chin well engaged under pubes. There was a remarkable absence of cranial firmness, which I attributed to the unusual presentation and lack of familiarity on my part with such presentations. While the pains were very short for this stage of labor they were rhythmical, and considering the advance apparently already made, it was unaccountable to me why delivery did not take place. The face had remained almost stationary so long under repeated pains that I finally decided in the interest of the features of the child, to use forceps. It was then that my astonishment reached its climax, for in passing my finger into the vagina to guide the blade of my instrument, I could find no head to guide it around, but massive shoulders seemed to fill every available space and block nature in her efforts at delivery. I grasped the headless face, and tried to bring the right shoulder down upon the perineum, but apparently with no success. In my extremity I sent for my friend, Dr. Goethe, expecting the necessity of extracting body in sections; but happily for my own satisfaction and the preservation of my specimen, I succeeded in passing a twine in a catheter through the right axilla, and after drawing a strong tape through with it, succeeded in drawing the shoulder down, and with aid of my tape and right forefinger broke humerous and delivered right arm. The remainder was plain sailing, and I was happy in delivering the body without a single tear or bruise to the mother. The placenta was not of unusual size. The patient made a rapid and uneventful recovery without the establishment of active lactation.

I am sorry to weary you with the details of the case, but hope it may prove interesting in connection with the singular points presented for our consideration. The first thing is the brainless monster. How was it produced in a family where on both maternal and paternal sides there had never been a physical anomaly? Those who believe in maternal impression may find in the fright from the snake some resemblance between this monster and that symbol of subtlety and wisdom. And what is more apparent than what was suggested to me, that this mother, laboring under the terror of night, witnessing her home collapse in flame and smoke—what more natural than that she should transmit to her unborn child the wreck and ruin that she saw, and in the very citadel of this divine temple actually duplicate the sorrows and woe of that night? I shall leave this to those inclined to such things, with the suggestion that there is ample room for the imagination.

Possibly there may have been a connection between this anomaly and the poor health, with repeated shocks, which the mother suffered during her pregnancy.

But, leaving the arena of speculation and imagination to those interested in embryology and teratology, I turn to those especially instructive to the obstetrician. I refer, in the first place, to the long period of gestation. I believe that while no one attempts to determine definitely the exact number of days in a normal pregnancy, all agree that they are about two hundred and eighty. But here is a case in which, beyond a doubt, gestation lasted for three hundred and forty-five days, or an excess over a normal period of sixty-five days. I am positive of this. The lady is a lady of intelligence, and she is most emphatic as to the period of last menstruation, her morning sickness, and the time of quickening. But this is not all. In the face of two normal pregnancies and normally developed children of a normal size, she gives birth to a headless monster of extraordinary size, weighing at least ten pounds and possibly twelve. Were there a cranium and contents of a proportionate size, this child must have weighed at least fourteen or fifteen pounds—double the size of her former children.

I believe it is an established principle that pelvic abnormalities, causing more or less obstruction to the outlet of the womb, may cause a prolongation of pregnancy; but this case demonstrated a normal pelvis by two normal births, and, with much difficulty, this large body.

There are then these two facts that remain, to my

From Transactions of the Medical Association of Georgia, Forty-eighth Annual Session, 1897.

mind at least, associated as cause and effect: the absent cranium and the long period of pregnancy; and we must conclude that the head and calcified cranium of the fetus is a decided factor in closing the term of a gravid uterus.

The factors which are generally accepted as entering into the precipitation of labor may be briefly summarized as follows: The tension to which the muscular fibers of the womb are subjected in the last months of pregnancy, and their reaction therefrom; the increased irritability of the gravid uterus at menstrual epochs; the progressive changes in tissue and the circulation of the blood about the attachment of the decidua, causing its easy response to an irritable womb in separating, and so acting as a foreign body. But would these causes so combine if there were no firm cranium to respond to their call, and so increase irritability of the uterus by its hard and unresilient pressure upon its wall as to whip it into active and permanent contractions? My case would seem to answer, "No."

Furthermore, I find, on investigation, that as a rule these acranial monsters are of unusual size, and are spoken of as bodies of fine development. Is it not possible that, as a rule, these monsters, like this specimen, were over term, and attained their malignant growth by extended life *in utero?*

TRANSPLANTATION SOCIETY WILL MEET IN SEPTEMBER

The Second International Congress of the Transplantation Society will meet at the Americana Hotel in New York City September 7 through 11, 1968.

John Marquise Converse, M.D., president of the Transplantation Society and Lawrence D. Bell professor of surgery at the New York University Medical Center, said that more than 2,000 members and their guests from around the globe are expected to register for the five-day conclave, which is sponsored by The John A. Hartford Foundation, Inc.

The scientific program of the Congress will feature, among other items, sessions on bone marrow transplantation, and cancer and pregnancy in their relationship to transplantation. A full day will be devoted to the transplantation of organs, including kidney, heart, liver, lung and others. Body rejection of alien tissue will be covered at length. Prominent specialists in these areas will lead the discussions.

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Oxyhemoglobin	4.0% ±	2.0% ±	30 sec.	.09 -.16
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1968 CALENDAR OF MEETINGS

April 14-17—Atlanta Graduate Medical Assembly, Marriott Motor Hotel, Atlanta, Ga.

April 17 or 18—Short Course on Procto-Sigmoidoscopy sponsored by Georgia Baptist Hospital Atlanta Medical Center and Georgia Division, American Cancer Society, in conjunction with Atlanta Graduate Medical Assembly. April 17 at Marriott or April 18 at Georgia Baptist Hospital.

April 18—Third District Medical Society, Muscogee County Medical Society, Ralston Hotel, Columbus, Ga. Registration 1 p.m.

April 19-20—Georgia Society of Medical Technologists, Executive Park Motel, Atlanta, Ga.

April 24—Seminar on Colon-Rectal Diseases, Georgia Baptist Hospital Auditorium, Atlanta, Ga. Sponsored by Georgia Baptist Hospital, Atlanta Medical Center, Atlanta Metropolitan Units, American Cancer Society.

May 5-7, 1968—114th Annual Session of the Medical Association of Georgia, Town House, Augusta.

National

April 16-17—American Association of Planned Parenthood Physicians, Gunter Hotel, San Antonio, Tex.

April 17-20—American Association for the History of Medicine, Chase Park Plaza, St. Louis, Mo.

April 20-21—American Society for Artificial Internal Organs, Bellevue-Stratford Hotel, Philadelphia, Pa.

April 21-22—American Broncho-Esophagological Association, Hollywood Beach Hotel, Hollywood Beach, Fla.

April 21-26—American Laryngological, Rhinological and Otological Society, Hollywood Beach Hotel, Hollywood Beach, Fla.

April 22-24—American Association for Thoracic Surgery, Pittsburgh-Hilton Hotel, Pittsburgh, Pa.

April 22-25—American Orthopaedic Association, Boca Raton Club, Boca Raton, Fla.

April 22-27—American Academy of Neurology, Pick-Congress Hotel, Chicago, Ill.

April 25—American Society for Head and Neck Surgery, Hollywood Beach Hotel, Hollywood, Fla.

April 25-26—American Geriatrics Society, Roosevelt Hotel, New Orleans, La.

April 25-28—American Academy of Physical Medicine and Rehabilitation, Sheraton-Chicago, Chicago, Ill.

April 27-May 1—American Academy of Facial Plastic and Reconstructive Surgery, Diplomat Hotel, Hollywood Beach, Fla.

April 28-May 1—American Association of Plastic Surgeons, Shamrock-Hilton Hotel, Houston, Tex.

May 1-2—American Pediatric Society, Seaside Hotel, Atlantic City, N.J.

May 3-4—Society for Pediatric Research, Seaside Hotel, Atlantic City, N.J.

May 13-16—American Urological Association, Fontainebleau Hotel, Miami Beach, Fla.

May 19-22—National Tuberculosis Association, Rice Hotel, Houston, Texas.

May 19-23—American Thoracic Society, Rice Hotel, Houston, Texas.

May 27-29—American Ophthalmological Society, Homestead, Hot Springs, Va.

June 13-17—American College of Chest Physicians, Hilton Hotel, San Francisco, Calif.

June 15-16—American Diabetes Association, Sheraton Plaza, San Francisco, Calif.

June 16-20—American Medical Association Annual Meeting, San Francisco, Calif.

June 16-20—American College of Preventive Medicine, San Francisco, Calif.

June 18-19—American Medical Women's Association, Waldorf Astoria Hotel, New York, N.Y.

June 30-July 3—International Congress of Primatology, Biltmore Hotel, Atlanta, Ga.

THE MONTH IN WASHINGTON

The American Medical Association and the Association of American Medical Colleges announced a joint policy statement calling for a substantial increase in the number of medical students.

Dr. Milford O. Rouse, president of the AMA and Dr. John Parks, president of the AAMC, reviewed the joint statement at a news conference in Washington.

The statement "emphasized the urgent and critical need for more physicians if national expectations for health services are to be realized." The statement said:

"National policy which would best meet this need, and would be consistent with the American ideal of equal educational opportunity for all, would provide such educational resources that every young person interested in and qualified for entry to the study of medicine would have this opportunity. Both Associations endorsed the position that all medical schools should now accept as a goal the expansion of their collective enrollments to a level that permits all qualified applicants to be admitted. As a nation, we should address the task of realizing this policy goal with a sense of great urgency.

"In their endorsement of and call for broadening educational opportunity for the study of medicine, both Associations stressed that the length of time necessary to realize such a goal does not minimize the need to respond to today's critical shortage of physician manpower. In order to enable the nation's medical schools both to meet today's crisis and to attain the longer-range goal of unrestricted educational opportunity, those responsible for allocation of resources must recognize the magnitude of these tasks."

Steps Should Be Taken

The two associations said both immediate and long-range steps should be taken.

The immediate steps are:

1. To increase the enrollment of existing medical schools.
2. To foster curricular innovations and other changes in the educational programs which could shorten the time required for a medical education and minimize the costs.
3. To meet the need for innovation in educational programs and to encourage diversity in the character and objectives of medical schools. The development of schools of quality where a primary mission is the preparation of able physicians for clinical practice as economically and rapidly as possible is to be encouraged. . . .

"A longer-range approach to the need for physicians is the development of new medical schools," the statement said. "This approach will not solve our immediate, urgent need for more physicians but it is essential for meeting the national needs of 1980 and beyond."

Long-Range Steps

The two associations said the longer-range program would require adequate financial support from governmental and various private sources for:

1. Construction of facilities to expand enrollment of existing schools and to create new schools.
2. Support of the operational costs of medical schools.
3. Stimulation and incentive for educational innovation and improvement.

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MONTH IN WASHINGTON / Cont'd

"To implement these measures will further require that each medical school and its university reexamine its objectives, its educational program, and its resources to determine how it can contribute most effectively to the national need for more physicians and what financial help it will need to make this contribution," the statement said. "Also required is understanding by the public, the private foundations, industry, local and state governments, and the national Congress—groups which must provide the financial support which is necessary.

"Initiative for development of new schools and expansion of the established institutions should be locally determined. Only the governing bodies of schools with ongoing programs in medical education can decide to expand such programs. Institutions wishing to organize new medical schools must assume the responsibility for marshalling the necessary support. Both associations are prepared to lend any assistance they can to such efforts."

Johnson Asks Price Control

In a health message to Congress, President Johnson proposed control of prices of drugs bought for government programs and asked for authority for the Food and Drug Administration to publish a drug compendium financed by drug manufacturers. He also asked for more money for health manpower and the maternity and child health programs.

With an objective of lowering costs, he also asked for authority for the Health, Education and Welfare Department to establish new formulas for reimbursement of hospitals and physicians under medicare, medicaid and maternal and child health programs. The Social Security Administration immediately announced that it would begin "an experimental program to find methods of reimbursing hospitals and doctors that will have built-in incentives to efficiency and economy."

Participation in such experiments would be entirely voluntary, the SSA said. And Congress would have to approve the necessary legislation before new methods of reimbursement could be put in effect on a mandatory basis.

Under medicare, a physician now is reimbursed on the basis of his usual and customary fee if it is considered reasonable.

HEW said two methods of reimbursement involving physicians that might be tried are:

—Group practice prepayment plans which offer comprehensive health services to their members could be reimbursed on a set per capita rate for the ensuing period.

—For physicians' services, experimental bases of payment might be a single fee related to total illness services rather than individual fees for each individual visit and individual service, agreed-upon fees held stable for specified periods, fees related to physician-time, or retainer or per capita payments per year for services of a specified kind.

Commenting on Mr. Johnson's health message, Dr. Rouse said:

"There is great need for expanded health care service in the United States. Meeting this need requires devoting attention to all the elements involved in the supply of resources and manpower, the distribution of health care, and costs.

"The AMA supports private and governmental programs that help those who need help. Health care for all the people should be expanded in an orderly way so resources and needs are increased together and at comparable rates of growth.

"Government can and should support the construction and renovation of hospitals and extended care facilities, and together with the states and private sources, should promote a rapid increase in medical manpower.

Rouse Advocates Competition

"As for drug prices, we believe that every patient should be able to buy high quality prescription drugs at the lowest possible price. The way to accomplish this is to promote more effective price competition at the retail level, which will result in lower prescription drug prices for everyone. This should be the thrust of government programs—not price fixing for one group. Everyone should be encouraged to be more price conscious in buying prescription drugs. The physician should include both medical and price considerations in writing prescriptions and the patient should patronize that pharmacy that can furnish dependable service and and the prescribed product at the lowest possible price. . . .

"The President's message contains little essentially new. It concentrates again on pouring additional millions of dollars into a health care system that is already facing requirements well beyond what it can now meet.

"Government expenditures for health care should be moderated during this period of acute shortage to control rapidly rising cost. Government can be most helpful by controlling inflation and by providing tax deductions and credits for people purchasing health insurance. . . .

"The physicians of this country will welcome a genuine partnership in health, where the Federal government will sincerely and continually seek the advice and active collaboration of those whose special services lie in medical education and the planning and provision of superior quality medical care for all citizens."

Heart Transplant Guidelines

The Board of Medicine of the National Academy of Sciences stated that the transplantation of human hearts still is in the experimental stage and proposed three guidelines for the procedure.

The Board said human cardiac transplantation should only be carried out in institutions in which these three criteria can be met:

1. The transplant teams should be highly skilled and have had extensive laboratory experience.
2. The work should be carefully planned, and the results should be rapidly communicated to others in the field.
3. Both the teams and the patients should be protected by "rigid safeguards."

* * *

A check is being made to determine how many alien physicians, dentists and "allied specialists" are now subject to draft laws. A new law for the first time makes aliens in the medical and dental professions subject to draft up to age of 35.

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TREATMENT OF ACTINIC KERATOSES WITH AN ANTIMETABOLITE / SEE PAGE 205

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JOURNAL OF THE MEDICAL ASSOCIATION Georgia

Treatment of Actinic Keratoses With Topical 5-Fluorouracil

HIRAM M. STURM, M.D., *and* HARRY SCOTT, M.D., *Atlanta*

Very effective results were achieved with the local application of this new antimetabolite.

THE TREATMENT OF multiple actinic keratoses in clinical practice is a common and often challenging problem. Modes of therapy include dessication and curettage, curettage alone, cryotherapy with liquid nitrogen and carbon dioxide, chemotherapy, excision and dermabrasion. Since virtually all therapy is effective against the actinic keratoses, the approach to therapy is to choose that method which has the least morbidity for the patient, and which is least time-consuming for the physician. Topical 5-Fluorouracil (5FU) is now considered by some to be the best available method for the treatment of widespread actinic keratoses.[7]

First Synthesized in 1957

Heidelberger et al[12] first synthesized 5FU in 1957 and demonstrated its antitumor effect when used systemically. The molecule of 5FU possesses stearic properties so close to uracil that it may follow the metabolic pathway of uracil and be synthesized into RNA.[4] In addition, it prevents thymine synthesis by inhibition of thymidilate synthetase[5] and suppresses the utilization of preformed uracil by blocking uracil phosphatase.[18] Dillaha et al speculate that topical 5FU follows its established route of action, being incorporated into cellular RNA in place of uracil and blocking conversion of uridine monophosphate to thymidine monophosphate.[8]

Falkson and Schultz,[11] while using 5FU systemically, had the impression that prolonged cancer chemotherapy with 5FU led to a smoothing and general softening of skin texture. They noted photosensitivity and the disappearance of actinic keratoses in some of their patients. These findings provided the clues which led to the use of topical 5FU to treat actinic keratoses and skin neoplasms. The first reported topical application of 5FU was by Klein[13] and associates who employed a 20 per cent concentration of 5FU in hydrophilic ointment to treat one case of keratoacanthoma and two cases of metastatic adenocarcinoma. They noted partial erosion of the tumors without alteration of the surrounding normal skin. In a series of cases reported in the Archives of Dermatology in September 1963, Dillaha,[8] Jansen, Honeycutt and Bradford pointed out the selective cytotoxic effect of topical 5FU used on actinic keratoses. This baseline study by Dillaha and associates led to our clinical use of 5FU.

Technique

The initial use of 5FU employed a 20 per cent concentration in hydrophilic petrolatum.[7, 12] Subsequently, it was observed that an adequate therapeutic effect could be obtained with a five per cent concentrate in an ointment base.[9] At the present time the most convenient preparation both from the standpoint of patient acceptance and ease of formulation is the one per cent concentration in propylene glycol. This is prepared by mixing one 10cc vial of 5 Fluorouracil 500mg (Roche), with 40cc of propylene glycol.

The patient is instructed to apply the 5FU preparation twice daily, thoroughly rubbing it over the affected areas with the fingers. The patient should

From the Department of Medicine (Dermatology), Emory University, Atlanta, Georgia.
Presented at the 113th Annual Session of the Medical Association of Georgia, Atlanta, Georgia, April 30, 1967.

be advised to treat all areas rather than just the obvious clinical lesions as the subclinical lesions will also respond, whereas contiguous skin areas which are not actinically damaged will show no inflammation. The average patient will begin to display erythema and crusting in four to seven days, and in areas of more marked reaction, there may be erosion and superficial ulceration. It is during this time that one is impressed by areas of reaction that were not clinically discernable as actinic keratoses, whereas adjacent skin with similar appearance but in areas of lesser sun exposure show no reaction. This "search and destroy" action of 5FU at the site of actinically damaged skin accounts for its superb performance. Patients are checked weekly or biweekly, depending upon the extensiveness and severity of the keratoses. Initially all patients were treated for a full four weeks course; but in recent months, we have observed that patients who experienced the more marked inflammatory reactions, with heavy crusting and erosion, could discontinue their applications in two to three weeks with equally good therapeutic results. On the other hand, some patients continued the applications over a six to eight week period. In these, the inflammatory reaction seemed to reach a plateau in two to four weeks, continuing at this same level until the applications were discontinued, whereupon the crusting and erythema subsided with good post-treatment clearing of keratoses.

Skin creases, the naso-labial folds, angles of the eyes and the mouth were frequent sites of excessive inflammatory reaction and patients should be cautioned to avoid excessive treatment of these areas.

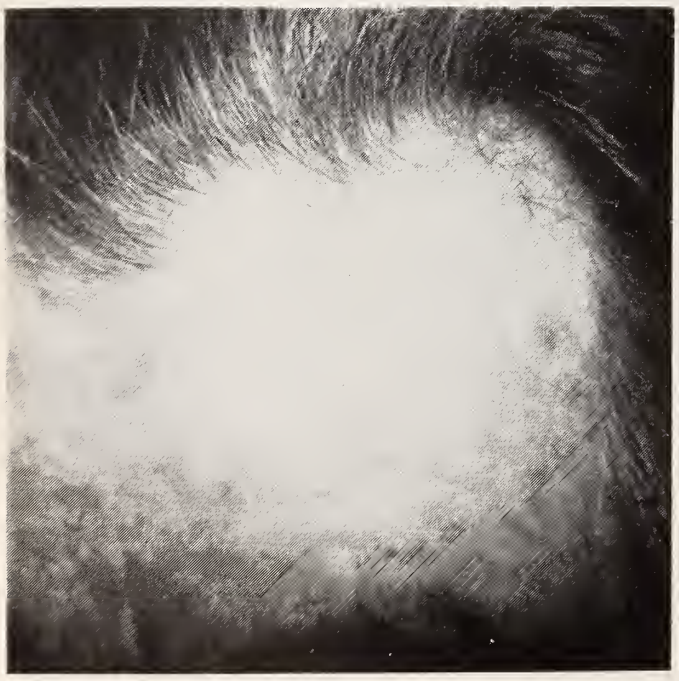

FIGURE 1

Multiple actinic keratoses of forehead, pre-treatment.

Patients were advised to omit an application or two before resuming treatment when areas became too inflamed or crusted or excessively tender. Occasionally these overly reactive areas were compressed with a colloidal solution (aluminum subacetate, magnesium sulfate, etc.) to relieve edema, or a corticosteroid cream was applied for its anti-inflammatory effect, without interference with the overall therapeutic effect.

Reactions to Sunlight Increased

Our clinical observation that patients using 5FU topically have increased reactions upon exposure to sunlight is in keeping with the original observations of Falkson and Schultz[11] who observed that 31 of 85 patients on systemic 5FU were sensitive to sunlight, and of Dillaha et al[8] who noted photosensitivity in many of their patients who were using topical 5FU for the treatment of actinic keratoses. One of our patients, while treating multiple keratoses of the face, neck, dorsal hands, and forearms with topical 5FU, inadvertently had prolonged sun exposure while doing yard work. Prior to the extreme sun exposure, he had an average moderate degree of erythema and crusting of the face and neck from 5FU as normally seen at the two to three week level of treatment. Over the dorsal hands and forearms he had experienced only a modest (inadequate) inflammatory response. Following the sun exposure, there was heavy crusting of the face and neck with exudation and tenderness, with a marked degree of erythema, crusting and exudation of the hands and forearms. With this observation of enhanced therapeutic response, over a formerly unresponsive area such as the forearm, a few patients have been exposed intentionally to increased increments of sunlight. It would appear that cases so exposed do show photosensitivity with topical 5FU, developing increased inflammatory reaction, and subsequently displaying more rapid and more effective clearing of actinic keratoses.

Since Nurse[15] observed that five per cent 5FU ointment under occlusive dressings produced erosion and clearing of psoriasis, and erosion and pigmentation of normal skin, others[6, 16] have treated patients with actinic keratoses with 5FU under polyethylene plastic dressing occlusion with enhancement of erythema and erosion. Our experience with this added dimension in the use of topical 5FU has not been adequate to date for evaluation purposes.

Excellent Response to Full Regimen

The therapeutic response of patients who followed the full regimen of two to four weeks of application of the 5FU (whether the five per cent ointment or the one per cent propylene glycol preparation was used), was unequivocally excellent. One week fol-

FIGURE 2

Same patient as in Figure 1 after four weeks treatment with topical 5 Fluorouracil.

FIGURE 3

Same patient as in Figures 1 and 2 showing resolution one month after completion of 5 Fluorouracil treatment.

lowing the discontinuance of 5FU applications, the crusts have usually exfoliated, leaving a mild to moderate degree of erythema which usually subsides in another one to two weeks. Once the erythema has faded, the skin is generally smoother and freer of pigmentary variations than the actinically damaged skin was before treatment, and there is generally total clearing of all actinic keratoses.

It seems to hold true that the more intense the inflammatory reaction during therapy, the less the treatment time, the more effective the keratosis removal, and the more prolonged the time before new keratoses appear. A few patients were observed in whom prominent telangiectasia and vascular flushing were seen over the central face post-treatment. These vascular findings could have been present pre-treatment, being masked by hyperpigmentation and keratoses, or they may represent a true change in the skin as a result of treatment with 5FU. Our observations would tend to favor the former explanation, but only time and further case studies will help elucidate this.

A more striking response in many elderly patients with heavily wrinkled, actinically damaged skin was the marked reduction in wrinkling seen post-treatment. Thus the cosmetic, as well as the therapeutic response, was overall deemed excellent.

Toxicity

Studies of systemic toxicity from topically applied 5FU have been done by Dillaha et al.[8, 9] They calculated that 5.98 per cent of the topical dose of 5FU was absorbed systemically, using C-14 labeled 5FU. If two gm of the five per cent ointment are applied daily, this would result in five to six mgm of 5FU absorbed and is well below the maximum permissable dose of 1000mgm per day.

Clinical symptoms of systemic toxicity, ie., diarrhea, stomatitis, nausea and vomiting, alopecia, pharyngitis and esophagitis, and epistaxis have not been seen in our patients and we do not routinely obtain blood studies.

Treatment of Other Conditions

All who have treated nodulo-cystic basal cell epitheliomas and squamous cell carcinomas report variable response to 5FU. Erythema, erosion and crusting occur over most lesions, but total clearing of these lesions with 5FU is usually unpredictable and therefore of little value. As a rule, after completing treatment of the actinic keratoses in three to four weeks, the basal cell epitheliomas and epidermoid carcinomas appear as well delineated areas, with variable degrees of inflammatory reaction. These residual lesions are then treated by more conventional modalities.

Our experience with Bowen's disease (intraepidermal squamous cell carcinoma) of the neck, anterior and posterior chest and the hand (six cases) and with superficial basal cell epithelioma of the chest wall (two cases) has shown good clinical clearing, utilizing one per cent 5FU solution twice daily over a six to eight week period. Two other cases of Bowen's disease, one of the lateral neck and one of the dorsal forearm responded adequately only to a four per cent 5FU propylene glycol solution. Ade-

quate evaluation will only be possible after careful followup over the next two to three years, as Bowen's disease is so frequently locally recurrent. The actinic keratoses of Xeroderma pigmentosa have been shown to favorably respond to topical 5FU by Dillaha et al[7] as has Erythroplasia of Queyrat.

Histopathology

Dillaha et al[8] reported a similar histopathological pattern in each patient studied by serial biopsies. The first change noted is edema at the basal cell layer and at areas of anaplasia. This edema gradually increases to involve adjoining layers of stratum malpighii. The anaplastic basal and squamous cells become markedly enlarged with bizarre nuclei and an acantholytic-like process is observed in the epidermis. The usual mononuclear inflammatory infiltrate seen in the upper dermis with active keratoses seems to become more intense at this stage. Subsequently epithelial cells separate from the dermis, resulting in a pink staining surface coagulum, containing parakeratotic nuclear material. The histopathologic studies seem to verify the clinical observations of the reaction of 5FU on the skin and its selective effect on anaplastic cells. Our few cases studied histopathologically have shown findings similar to those of Dillaha et al.

Comment

Historically the treatment of senile (actinic) keratoses and other premalignant lesions of the skin such as Bowen's disease has been in the realm of responsibility of the dermatologist. With this responsibility in mind, we dermatologists have practiced good prophylactic medicine over the years by having patients with moderately to severely damaged actinic skin return for periodic checkups. Every three to six months, all significant lesions were removed. Through the routine periodic removal of these premalignant lesions, the incidence of degeneration into epidermoid carcinoma and basal cell epithelioma was markedly reduced. At times, in patients with frequently occurring crops of keratoses, removal of all epidermis and much of the solar damaged dermis of the skin of the face has been carried out through dermabrasion (surgical skin planing). The occurrence of actinic keratoses in these postabrasion patients has been practically eliminated over a four or five year followup period as observed by one of the authors (HMS) as well as by others.[2, 3, 10, 17] This procedure had the merit of removing not only active actinic keratoses present at the time of surgery but also removed the adjacent skin areas with subclinical keratoses, while at the same time removing the substrate, the actinically damaged dermis.[14]

Procedure as Effective as Dermabrasion

With the availability of topical therapy with 5FU, our results would tend to indicate that we have a procedure as effective as dermabrasion for the removal of actinic keratoses, both active and subclinical in degree, while enjoying a course of treatment which the patient may carry out himself, with only physician observation and guidance over the two to four week course of therapy. Thus an expensive, time consuming mechanical-surgical technique (dermabrasion) for the treatment of precancerous skin lesions is replaced by a relatively simple, inexpensive, chemosurgical technique. Observation in many of our elderly patients with severely actinically damaged skin would tend to indicate that there also has been replacement in regenerative fashion of the actinically damaged dermis. In a few patients we have noticed a marked reduction in wrinkling post-treatment, further suggesting that there is replacement of damaged collagen.

After one and a half years' experience with 75 patients, it is not difficult to be enthusiastic about the

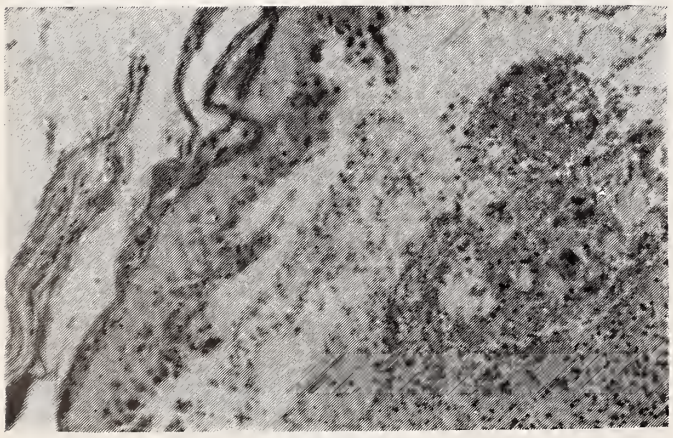

FIGURE 4

Biopsy of actinic keratosis at four weeks of topical 5 Fluorouracil treatment. Note epidermal-dermal separation.

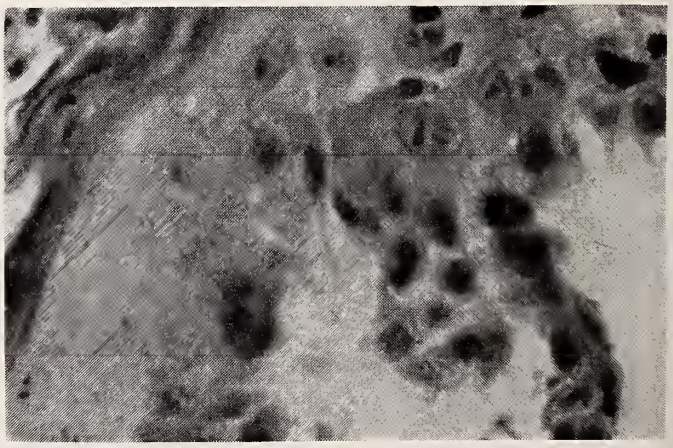

FIGURE 5

Higher power view of Figure 4 showing basal cell necrosis and an acantholytic-like process.

use of 5FU in the treatment of actinic keratoses of the skin. It is a modality which is proving effective in the removal of keratoses in a somewhat selective fashion since it does not produce reaction with nevi, seborrheic keratoses, other skin blemishes, nor with normal skin. The keratoses are removed in rather uniform fashion. They clear without leaving unslightly areas of hypopigmentation as would result from treatment of a single or a few lesions by means of dessication and curettage, curettage alone, or with cryotherapy. Apparent disadvantages in using 5FU in the treatment of actinic keratoses include: results which are less predictable over some body areas, such as the posterior neck, the dorsal hands and forearms; the unslightly physical appearance of the treated areas while undergoing crusting, scaling and exfoliation for the two to four week treatment period, and the associated discomfort which is not well tolerated by some individuals. In a random sampling of patients, less than 10 per cent withdrew from the course of treatment for reasons of discomfort or unsightliness. A majority of these cases were women, for we observed many active businessmen who were able to continue their fulltime activity while undergoing a course of treatment over the face, scalp, and forearms. Further refinements and adaptations in the use of 5FU topically should result in its acceptance as one of our superior dermatologic modalities.

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EMORY DEDICATES CLINICAL PHARMACOLOGY CENTER

Quicker application of new drugs to the medical problems of patients will be made possible by a new clinical pharmacology center dedicated by Emory University last month.

The new day treatment ward (of Emory's Department of Medicine) dedicated at Grady Hospital has actually been in use since late last October, Dr. Leon I. Goldberg, director of Emory's Clinical Pharmacology Unit, explained.

"It is difficult to get a new drug to the public," Dr. Goldberg commented. He explained the long period of trial and testing beginning with the extracting of the new drug and an extensive period of testing on animals to determine its pharmacological properties, followed by toxicological studies on animals. Drugs are then tested by drug houses on human volunteers, Dr. Goldberg said.

The purpose of the clinical pharmacology center at Grady is to take care of patients untreatable with available drugs, Dr. Goldberg said.

"We select patients who have a special problem. They must volunteer and be assigned to be treated with a new drug. The patient must be willing to come back when he is told to."

Dr. Goldberg said tests of new drugs had to be approved by the Food and Drug Administration and by Emory's Clinical Trials Committee which consists of eight physicians from various specialties. Data is reported to the drug companies. Any unusual effects are reported immediately.

Emory's work is supported by a $474,849 grant from the National Institute of General Medical Sciences. In addition to the day treatment ward at Grady Hospital there are six beds at the Clinical Research Facility at Emory University Hospital where in-patients may be kept under close observation for extended periods.

The characteristic small vessel alterations in this infection are thought to underlie these dual complications.

Rocky Mountain Spotted Fever With Thrombocytopenia and Atrial Fibrillation: A Case Report

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UNUSUAL MANIFESTATIONS of Rocky Mountain spotted fever have been reported with increasing frequency. Thrombocytopenia has been found in several cases.[1] Myocardial involvement in rickettsial infections is well known,[2] but documented arrhythmias have been rare.[3, 4] It is the purpose of this paper to report a case of Rocky Mountain spotted fever with both atrial fibrillation and thrombocytopenia and to suggest the likelihood of a common pathogenesis for these two complications.

Case Report

F. C., a 57 year old white male, was admitted to the Georgia Baptist Hospital, Atlanta, Georgia, on August 14, 1966, with a maculopapular rash, fever, mental confusion, and atrial fibrillation. Three weeks prior to admission he picked ticks from his dog and brushed an unattached tick from his arm. He denied being bitten by the tick, but admitted having an infected area on the exposed arm. Seven days prior to admission he developed generalized weakness, shortness of breath, wheezing, a temperature of 103°F., and myalgia. Three days later he was seen by his physician and treated with penicillin and streptomycin. The fever persisted with chills, and he was started on tetracycline two days prior to admission. One day later he developed a cloudy sensorium, slow speech, a generalized maculopapular rash, and an irregular pulse. An electrocardiogram at that time revealed atrial fibrillation with rapid ventricular response. Cerebrospinal fluid was negative. Digitalis therapy was initiated.

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On admission the pulse was 110 beats per minute and was irregular in rhythm and intensity. The blood pressure was 130/98 mm. Hg. Respirations were 28 per minute, and the oral temperature was 101.6°F. His speech was slurred, and he was moderately disoriented. A maculopapular rash which blanched under pressure was present on the trunk and extremities. There were no enlarged lymph nodes or petechiae. The neck was supple and without neck vein distention. The chest contained bilateral inspiratory and expiratory wheezes and bilateral posterior basilar rales. The heart rhythm was grossly irregular, but there were no associated murmurs, gallops, or rubs. The liver and spleen were not palpable. The knee and ankle jerks were absent, and there was no reponse to plantar stimulation.

The white blood cell count was 4,036 with a differential of 72 per cent segmented cells, 13 per cent bands, 12 per cent lymphocytes, and three per cent monocytes. The platelet count was 28,000/cu. mm., dropping to 10,000/cu. mm. after one day. The hematocrit was 46 volumes per cent. A urinalysis revealed four-plus albumin and numerous coarsely granular casts. Additional laboratory values revealed the following: blood urea nitrogen 42 mg/100 cc.; serum carbon dioxide 20.1 meq/liter; serum chloride 94.7 meq/liter; serum sodium 128 meq/liter; serum potassium 4.4 meq/liter. Total serum protein was 5.9 gm/100 ml. with 2.7 gm/100 ml. albumin and 3.2 gm/100 ml. globulin. Bone marrow examination revealed normal maturation of both myeloid and erythroid elements; megakaryocytes were present in adequate numbers; no rickettsial organisms were found on special stains. Cultures of sputum, stool, urine, cerebrospinal fluid, and blood

were negative. Fibrindex, partial thromboplastin and prothrombin time were within normal limits. Fibrinolysin, direct and indirect Coombs' tests were negative. Agglutinations for typhoid O, paratyphoid A and B, brucella A, proteus OX-K, and heterophile antibodies were negative. In addition the following titers were obtained:

Dates	Proteus OX-19	Proteus OX-2	Typhoid H	Complement Fixation
8-14-66	1:20	1:20	1:40	1:8
8-15-66	1:80	1:80	1:80	—
8-16-66	1:160	1:80	1:160	—
8-17-66	1:160	1:160	1:20	—
8-18-66	1:1280	1:1280	1:20	—
8-22-66	1:2560	1:1280	—	1:8
8-25-66	1:2560	1:640	—	1:64
9-1-66	1:2560	1:160	—	1:32

A chest x-ray showed increased pulmonary vascularity suggestive of borderline congestive heart failure. The heart size was normal. An electrocardiogram revealed atrial fibrillation with rapid ventricular response.

On his second hospital day he became afebrile, but he developed a left hemiparesis, left-sided seizure activity, and became comatose. A tracheostomy was performed, and he was placed on assisted ventilation. The rash became petechial and nonblanching. At that time the differential diagnosis included Rocky Mountain spotted fever, meningococcemia, and thrombotic thrombocytopenia purpura. He was treated with prednisilone, oxytetracycline, penicillin, diphenylhydantoin, and phenobarbital. He also was transfused with eight units of platelet concentrate over a period of nine days.

By the third hospital day the heart rhythm had returned to normal. Two days later he had regained consciousness and was able to speak though he remained disoriented. By the ninth hospital day the platelet count was 112,000/cu. mm. He was discharged from the hospital after 39 days in normal sinus rhythm, with a platelet count of 242,000/cu. mm., having slight mental confusion, and with a moderate motor weakness in the right hand.

Discussion

Rocky Mountain spotted fever was first described in this country in 1896,[5] and *R. rickettsii* was identified as the causative organism in 1919.[2] The disease is limited to the western hemisphere, but has been found to be especially prevalent in the South Atlantic states.[6, 7]

The gross pathological changes in the disease are limited primarily to the skin. Most of the changes are microscopic and involve the small blood vessels.[8, 12] The rickettsias may invade the smooth muscle cells of the arteriolar walls as well as the vascular endothelium, thus causing an infectious angiitis. The lesions at first are proliferative, resulting in a growth of the endothelium which narrows the vessel lumen. This is followed by a necrosis of the endothelial cells and the deposition of fibrin. Mural thrombi, which frequently occlude arterioles, capillaries, and venules, may be formed. The lymphatics are not involved.[13] Such vascular lesions have been found in the following tissues: myocardium, liver, spleen, lymph node, bone marrow, adrenal, kidney, testes, brain, and striated muscle.[12]

The clinical findings of headache, fever, chills, myalgia, joint pain, cough, photophobia, pneumonitis, skin rash and central nervous system involvement have been common in Rocky Mountain spotted fever. Thrombocytopenia and cardiac arrhythmias have been infrequent. Schaffner and co-workers[1] recently described two cases of Rocky Mountain spotted fever with thrombocytopenia and reviewed the literature of cases where platelet counts or impressions of platelet adequacy were mentioned. Out of 33 cases, 20 were felt to have thrombocytopenia. They also reviewed 18 cases from Vanderbilt University, six of which manifested thrombocytopenia. The available data is inadequate for determining the actual incidence of thrombocytopenia in Rocky Mountain spotted fever. It does suggest that the frequency is much greater than previously recognized.

Platelet Deficiency

The etiology of this phenomenon is not known. Kelsey and Harrell,[14] Trigg,[15] and Atkins, et al.,[16] found a platelet deficiency in this disease associated with a marked hypofibrinogenemia and/or a deficiency in the vitamin K-dependent factors II, VII, and IX. In the case presented here there was a normal fibrindex, prothrombin time and partial thromboplastin time; the test for fibrinolysins was negative. Mengel and Trygstad[17] raised the question of immunologic factors or possible toxic effects on the bone marrow. Phillips[18] found a sharply diminished number of megakaryocytes in the only other reported bone marrow specimen taken from a living patient. In the patient described here the bone marrow revealed adequate megakaryocytes, platelets, and other cellular elements, indicating no suppression in platelet production. The bone marrow specimen obtained at autopsy in the Vanderbilt cases[1] also contained the usual number of megakaryocytes. It seems most likely that the thrombocytopenia is related to the intravascular clotting phenomenon which results from the vasculitis that is characteristic of Rocky Mountain spotted fever.[1, 12]

In all reported survivors of the disease, the platelet count has returned to normal. The 10,000 plate-

lets/cu. mm. reported here is the lowest known count in any patient who has survived. In addition to tetracycline, corticosteroids as well as platelet transfusions may be indicated whenever an associated thrombocytopenia is detected in this disease.

Atrial Fibrillation

The patient presented was found to have atrial fibrillation. Routine electrocardiographs over the past several years had revealed the presence of no previous cardiac arrhythmias. A review of the literature since 1916 produced only two other documented cases of arrhythmias other than sinus tachycardia, in patients with Rocky Mountain spotted fever. Aquilina and co-workers[3] described one patient with a nodal tachycardia, and Woodward[4] reported a case with atrial fibrillation.

Again, the etiology of this complication has not been determined. Vasculitis and intravascular clotting produce interstitial edema, mononuclear cell infiltration, and muscle fiber degeneration in the heart.[19, 21] This myocarditis may well account for the congestive heart failure that occasionally is seen in Rocky Mountain spotted fever apart from arrhythmias, and may explain the less frequent conduction disturbances. Arrhythmias are known to occur in thrombotic thrombocytopenia purpura,[22] another disease characterized by intravascular coagulation. James[23] has recently correlated the pathology of the conduction system of the heart in this disease with the associated rhythm disturbances. A similar correlation is possible in Rocky Mountain spotted fever. It seems likely that the etiology of the arrhythmias as well as the thrombocytopenia in this disease has its foundation in the characteristic small-vessel alterations.

It might be concluded from this report that the presence of arrhythmias and thrombocytopenia in Rocky Mountain spotted fever may be more common than has been previously recognized.

Summary

A case is presented of Rocky Mountain spotted fever with thrombocytopenia and atrial fibrillation. A platelet count of 10,000/cu. mm. represents the lowest number of platelets recorded in any patient who has survived this disease. Bone marrow examination showed no abnormalities, and there were no associated clotting deficiencies. This case represents the third patient with a documented cardiac arrhythmia in Rocky Mountain spotted fever. The etiology of these two complications is discussed, and it is suggested that both phenomena probably result from the vasculitis and intravascular coagulation which characterize the disease. The proposal is made that both arrhythmias and thrombocytopenia may be more common in Rocky Mountain spotted fever than previously recognized.

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Immediate and significant improvement in the condition of both patients followed the procedures outlined in this paper.

Emergency Treatment of Transposition of the Great Vessels: A Report of Two Cases

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TRANSPOSITION OF THE GREAT VESSELS (TGV) is the most common cause of cyanosis and congestive heart failure in infancy.[1] It is now widely accepted that infants with TGV require evaluation as soon as the diagnosis is suspected and appropriate treatment before irreversible levels of myocardial failure and systemic acidosis are reached. The surgical techniques for palliative treatment of TGV carry high risks, especially when amplified by the presence of acidosis and myocardial deterioration. For these reasons, the introduction of a closed-chest palliative procedure by Rashkind[2] whereby the foramen ovale is enlarged using a balloon-tipped cardiac catheter has offered a chance to avoid surgery while stability is achieved. Enlargement of the foramen ovale or obliteration of the atrial septum allows mixing of the desaturated systemic blood and the oxygen-saturated blood returning via the pulmonary veins. The net result is an increase in the oxygen saturation in the systemic vessels. The purpose of this paper is to present, briefly, two patients with TGV in whom early diagnosis and treatment were probably life-saving.

Case Presentations

C. J. (ETMH #081-301) was born following an uneventful gestation weighing 3.5 kg. He was noted to develop cyanosis with crying and to have rather rapid respirations while in the newborn nursery. At six weeks of age, he began to feed poorly and a cardiac murmur was first heard. He began to have episodes of respiratory distress and at three months of age was referred to the Medical College of Georgia on December 29, 1966.

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Supported in part by NIH Grant #HE07266.

Physical examination then revealed a pulse rate of 144/min., respiratory rate of 42/min., and he weighed 4.4 kg. He was generally cyanotic. The lungs were clear to auscultation. A grade III/VI systolic murmur was heard over the base of the heart. The liver was palpable 3 cm. below the right costal margin. There was no digital clubbing. His blood pH on admission was 7.28 with CO2 17 mmHg. and a base deficit 10 mEq/L using the method of Astrup.[3]

Chest x-ray demonstrated enlargement of the cardiac silhouette in the transverse diameter and increased pulmonary vascular markings. The electrocardiogram revealed axis +175 degrees with the right ventricular voltage increased.

Cardiac Catheterization Performed

On the day of admission, the patient underwent cardiac catheterization at which time transposition of the great vessels with intact atrial and ventricular septa was confirmed and the foramen ovale was dilated using a balloon-tipped cardiac catheter. The balloon was inflated with 0.75 cc., 1.0 cc., and 1.5 cc. of contrast media successively for repeated dilatations. The chamber pressures and oxygen saturation data before and after the dilatation are seen in Table I. Following the procedure, right atrial oxygen saturation increased significantly. Figure 1 illustrates the balloon inflated in the left atrium at the position of passage through the foramen ovale. Figure 2 illustrates angiographically the shunting at atrial level produced by the procedure. The patient tolerated the procedure well and was discharged three days later.

He was readmitted after eight days with a 48 hour history of cough, fever and respiratory distress. On physical examination, he was found to have the

systolic murmur heard before and there was mild cyanosis of the hands and feet. X-ray revealed a smaller heart shadow than previously and a right middle lobe infiltrate was seen. Aerobacter bacillus was cultured and he responded well to antimicrobial agents. The cyanosis improved as the infection cleared.

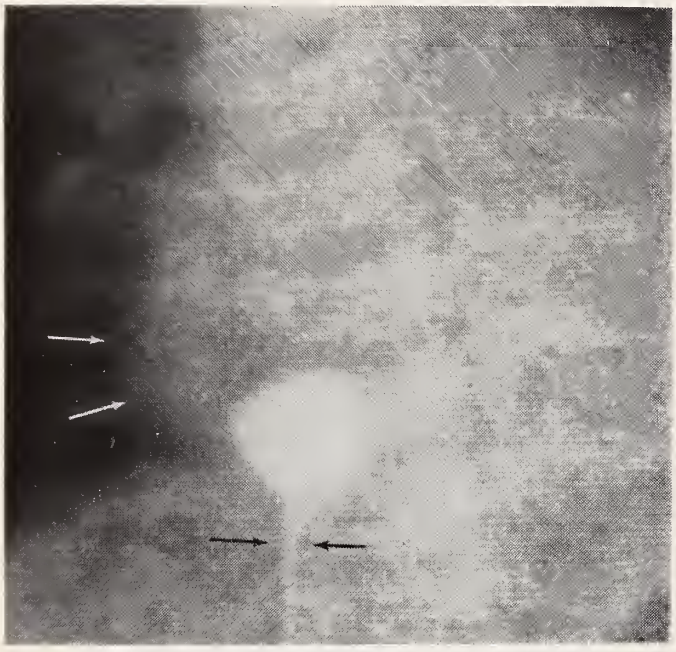

FIGURE 1

Frontal projection. Inflated balloon in the left atrium. At this stage, the balloon lies tightly against the foramen ovale and the interatrial septum has been drawn down medially and inferiorly approximating the orifice of the inferior vena cava. The inferior vena cava with the catheter in place is indicated by black arrows. The lateral wall of the right atrium by white arrows.

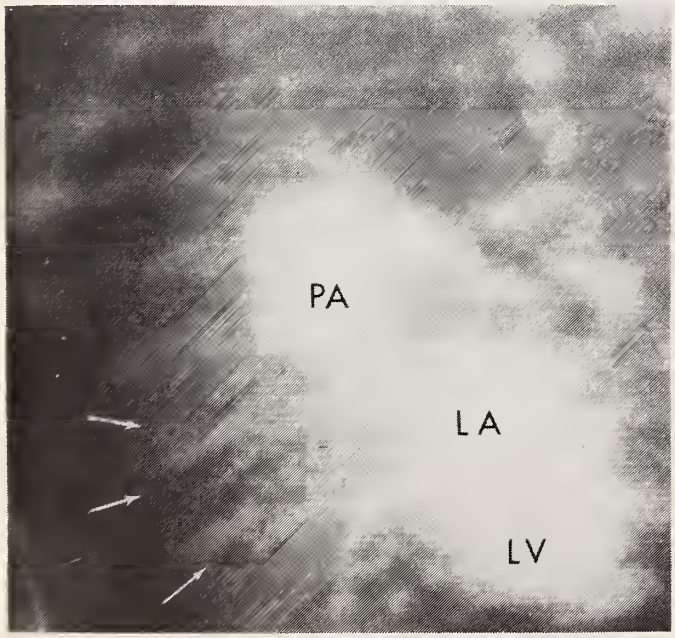

FIGURE 2a

Injection of contrast material within the left atrium (LA) before septostomy. LAO projection. The transposed pulmonary artery (PA) has opacified from the left ventricle (LV). Arrows indicate the right lateral border of the heart occupied by the right atrium and right ventricle which are non-opacified.

He was later admitted, three months after the cardiac catheterization, because of increasing hematocrit and deepening cyanosis. At that time, he was moderately cyanotic with no clubbing. Chest x-ray was unchanged as was the electrocardiogram. The prime consideration at this point was an inadequate interatrial communication. He underwent a Blalock-Hanlon procedure for creation surgically of an atrial septal defect, and did well post-operatively. His color improved and he was discharged on the fifteenth hospital day. His hematocrit has since fallen to 55 per cent and he is only mildly cyanotic. Three and one-half months post-operatively, at eight months of age, he weighed 8780 grams.

S. F. (ETMH #084-266) was the product of a normal pregnancy and delivery, born at term weighing 9 lbs. 14 ozs. He was cyanotic at birth and remained so despite oxygen therapy. At seven days of age, he was transferred to the Medical College of Georgia for treatment with a diagnosis of TGV.

On admission, his pulse rate was 150/min. and respirations 90/min. His hands and feet were moderately cyanotic and there was generalized cyanosis of the trunk and head. The lungs were clear. The left precordium was hyperactive. There was a grade 3/6 blowing systolic murmur heard over the chest, loudest along the left sternal border. The liver was palpable 3 cm. below the right costal margin. All peripheral pulses were palpable. His blood pH was 7.26 with a pCO2 42 mmHg. and a base deficit 8 mEq/L using the technique of Astrup.[3]

The electrocardiogram revealed axis +150 degrees, right atrial and right ventricular hypertrophy.

FIGURE 2b

Injection of contrast material into the LA following balloon atrial septostomy. LAO projection. Note the opacification of the previously non-opacified right heart structures indicating left to right shunting by way of the balloon created artial septal defect.

Chest x-ray demonstrated enlargement of all chambers of the heart with a narrow base. The vascularity of the lungs was normal.

Balloon Atrial Septostomy

On the afternoon of admission, following correction of his acidosis, the patient underwent cardiac catheterization. Transposition of the great vessels with intact atrial and ventricular septa was confirmed and balloon atrial septostomy performed in the manner described with patient C. J. Table I shows the pertinent data prior to and subsequent to the procedure. The infant improved markedly and was discharged on his third hospital day.

He did quite well, followed regularly in clinic with little or no cyanosis, until six months of age, at which time he was seen elsewhere for pharyngitis and otitis and was treated with antibiotics. Two days later, he was again seen in respiratory distress with grunting and bulging otitis media. He had venous distension and hepatomegaly and died following a Blalock-Hanlon procedure.

Autopsy confirmed the diagnosis of TGV. The foramen ovale was patent and measured 5 mm. in diameter. There was a 2½ cm. hole in the interatrial septum as a result of the surgery. The ventricular septum was intact. There was chronic passive congestion of the liver and pulmonary edema, hemorrhage and atalectasis. The pulmonary arterial tree was the site of significant hypertensive arterial disease with marked hypertrophy of the vessel walls.

Discussion

These two patients represent typical examples of transposition of the great vessels with no demonstrable intracardiac or extracardiac shunting. Both were cyanotic from birth but one pursued a prolonged course during which he remained remarkably stable while the other exhibited difficulty in the immediate newborn period. Both culminated in rapid deterioration with congestive heart failure, severe hypoxia and marked degrees of acidosis as previously existing fetal shunts were obliterated.

The procedure described by Rashkind[2] and employed in these two patients is performed at the time of diagnostic cardiac catheterization by placing a balloon-tipped catheter with the balloon deflated in the left atrium by way of the foramen ovale. Following inflation of the balloon, the catheter is withdrawn. The balloon thus enlarges the foramen ovale as it traverses this structure.

Improvement Followed

Immediate and significant improvement in the general conditions of both patients followed these procedures. It was possible to increase systemic oxygen saturation to levels, although significantly below normal, sufficient to maintain aerobic metabolic pathways with restoration of normal acid base balance[4] without assuming the high risk of surgical creation of an atrial septal defect in these ill infants. One patient has subsequently required this surgical procedure under elective conditions with low risk in a resonably stable situation. The other child, S. F., died following Blalock-Hanlon creation of an atrial septal defect. At the post mortem examination, severe pulmonary vascular changes were present. Evidence of such pulmonary vascular changes in patients with TGV has been documented by Ferencz[5] and is a significant cause of death in such patients. It is likely that the increased pulmonary vascular resistance consequent to this complication caused a reduction of pulmonary blood flow which, in addition to the small size of the interatrial defect, resulted in unrecognized progressive hypoxia. Terminally, challenge with a severe infection resulted in

TABLE I

	Pressure in mm.HG.				Blood O2 % Saturation	
	Phasic		Mean			
Catheter Position	Before Septostomy	After Septostomy	Before Septostomy	After Septostomy	Before Septostomy	After Septostomy
C. J.						
Left Atrium	A = 4	A = 4				
	V = 3.5	V = 4	2.5	2.5	99	99
Right Atrium	A = 5	A = 4				
	V = 3.5	V = 3	2.5	2.5	65	74
Right Ventricle	87/0/4				66	
S. F.						
Left Atrium	A = 24	A = 9	22	6	99	93
	V = 36	V = 12				
Right Atrium	A = 10	A = 7				
	V = 1	V = 5	3.5	4	56	82
Right Ventricle	75/0/12				59	73
Ascending Aorta	61/43				59	

acidosis with death following the operative procedure. The hypertensive pulmonary vascular disease found at necropsy was an unpredictable but severe complication well recognized in patients with TGV, which when present, precludes corrective surgery.

As seen in Table I, and demonstrated angiographically, both patients responded immediately to the septostomy with a shunting of pulmonary venous blood via the newly created interatrial defect to the right sided (systemic) structures. No post-operative convalescent period was required. Stabilization of their condition was almost immediate and their in-hospital period did not exceed that of the routine diagnostic study. At the time of discharge, both children were considered ideal candidates for open heart surgery.

Summary

Two patients with complete transposition of the great vessels are presented. Both were acidotic, cyanotic and in distress on admission to this hospital and were considered poor surgical risks. Cardiac catheterization was performed on both and in each an atrial septal defect was created using the technique of balloon septostomy with immediate improvement in the peripheral oxygen saturation and in the clinical status. One child required a Blalock-Hanlon creation of an atrial septal defect three months after catheterization and the other did well for six months post-catheterization when, after a fulminant otitis and pharyngitis, he became decompensated and died following an emergency Blalock-Hanlon procedure. Autopsy revealed findings of long-standing pulmonary hypertension.

The authors would like to acknowledge Dr. Fenwick T. Nichols and Dr. W. S. Medart, Jr., of Memorial Hospital of Chatham County for their cooperation in supplying us with the clinical and autopsy information on patient S. F.

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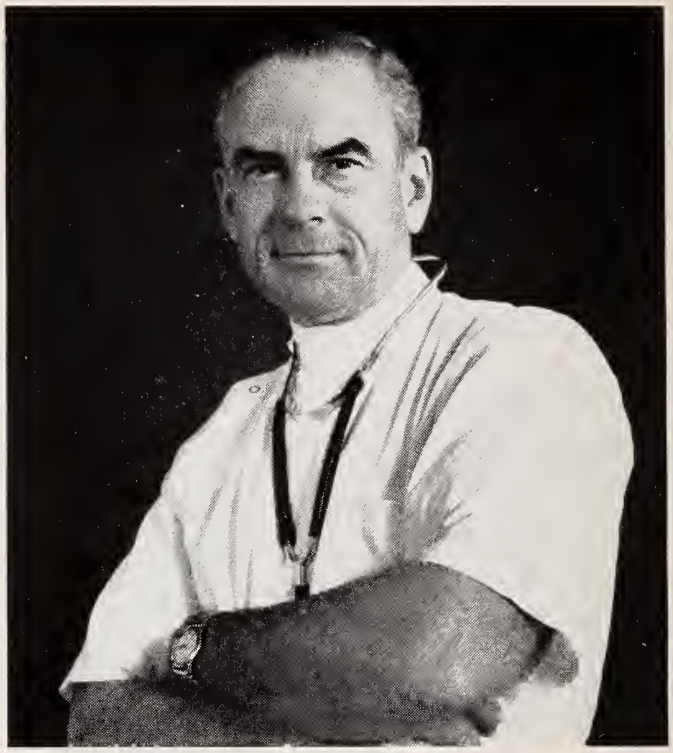

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Gasoline Inhalation

NYDA W. BROWN, M.D., *Augusta*

A case report and review of the literature.

THERE ARE FEW REPORTS in the literature of habitual intoxication achieved by the inhalation of gasoline. There is currently a survey in Georgia[8] to determine the extent of the drug abuse problem. The survey, sponsored by the Georgia Department of Public Health, includes LSD, opiates, amphetamines, etc., and specifically mentions an increase in police and medical reports of "glue sniffing," but no specific mention is made of gasoline fume sniffing.

In a review of the literature back to 1950, there were only 19 cases[2, 3, 5-7, 10-13, 15-19] of "gas sniffers" reported. Only six cases were noted in the 1950 to 1960 period, the remaining 13 occurring in 1961 to 1965. It is not known if there has been a real increase or simply an increase in reporting.

Effects Vary

The effects of gasoline depend not only on the amount inhaled over a given period of time, but also on the personality structure of the "sniffer." A variety of symptoms was reported by Tolan and Lingl,[19] who noted the similarity of gasoline intoxication to that of the "model psychosis" produced by LSD. The autonomic responses were unpleasant taste, increased salivation, nausea, drowsiness, light-headedness, dizziness, weakness and loss of appetite. Perceptual responses included a sense of physical lightness, hyperacusis, a sense of spinning and moving, floating, magnetic pull, distorted spatial relations, altered shapes and colors, visual, auditory and tactual hallucinations, micropsia, and amnesia. There were affective responses of fear, guilt, and loneliness. There were ideational misinterpretations and feelings of grandiosity.

Diverse clinical findings in individuals exposed to gasoline fumes have been noted. These findings are related to the chronicity of the exposure and the parts per million of gasoline in the air. The findings in a study of the effect of gasoline vapor in low concentration showed ocular irritation as an initial manifestation.[4] However, in high concentrations gasoline inhalation can be fatal as in the accidental death reported by Aidin[1] wherein the patient expired when he was procuring gasoline from a barrel in an enclosed, overheated shed.

Neuropathy in the form of foot drop[11] and/or other paralysis was the manifesting clinical symptom in two of the cases reported. These neuropathies resolved in eight to 12 months in each case after the patient ceased the gasoline inhalation.

The present report is about a 15-year-old boy who was studied and treated from June 7, 1965, to July 18, 1965.

Case Report

T. T., a 15-year-old white boy from Waycross, Georgia, was referred to Eugene Talmadge Hospital for psychiatric consultation because of a history of "gas sniffing" for approximately ten years. An isolated incident of "gas sniffing" was noted when the patient was 18 months old, at which time he crawled onto his uncle's motorcycle and sniffed the gasoline in the tank until he passed out. His mother found him lying beside the motorcycle in a stuporous state. The child repeated the episode at about age five years. The "gas sniffing" then became a regular occurrence for him. By the time the patient was ten years old, he was inhaling gasoline almost daily. He continued at that pace during his eleventh and twelfth year. He had a tent in his back yard in which he kept a can of gasoline attached to a garden hose. He sat in the tent on the ground and smelled gasoline until he became semi-conscious. He did not mind if people watched him as long as they did not interfere. His mother, father, brothers, sister and some neighbors tried to persuade and physically stop this boy from this habit. He became a particular problem to his mother when he was twelve years old, in that he was constantly argumentative. The patient and his

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mother had many bouts of yelling, screaming, and cursing at each other.

Spent Time Alone

The patient inhaled gasoline two to three times a week prior to admission here. Most of his time was spent alone; he did not participate in any family activities. His social life was vague without any particular direction. He just "messed around" with a few friends of whom his parents did not approve. He had complete freedom of hours since he paid little heed to restrictions. His parents stated that discipline was of no value.

The patient had always done poorly in school and flunked the first and fourth grades. He said his teachers and peers had always made fun of him and called him stupid. The teachers, in particular, he felt, seemed to regard him as a "hopeless case." His grades were F's, D's, and occasional C's. Although he worried about being stupid and uneducated, he did not like school. He dropped out of school just prior to coming for his evaluation.

Sniffing Increased Skills

He readily talked about "sniffing gas" and said he did this because he was able to do and feel many things while smelling gasoline which he could not ordinarily do. For instance, he stated ordinarily he could neither read nor write, but while under the influence of gas, he could write and also could read the Bible. He could see Jesus and people in white robes. He could communicate with his dead sister. He occasionally felt that his size changed so that sometimes he would be a giant and other times he would be very small. He knew exactly how to control his gasoline sniffing to keep from passing out. With the onset of a headache, he would quit sniffing until his head felt better; he would then resume sniffing until he again noted the headache.

Past History

Shortly after the patient's parents were married, the father was drafted into the Army. While the father was away, the mother had two sons by another man. The patient was the first child actually fathered by the husband. He has five younger brothers and sisters at home. The two older half-brothers are married. One of the patient's sisters died when she was nine and he was six. He said that this did not disturb him at the time, but she has frequently been a visitor in his hallucinations.

The patient stated that his mother constantly fights and curses his father. He does not like to hear his mother curse, and he calls her an old hag when she does this. The father drinks excessively on weekends, and the mother accuses the father of going out with women.

The age of 12 seemed to be a turning point in the patient's life. He became withdrawn, ill tempered, and difficult to manage. He stopped going hunting with his father and decreased associating with his family. He said that although he cared about his parents, particularly his father, he also hated them and he frequently heard a voice telling him that he should leave home.

Social History

Both parents are in their middle 40's. They talked about their son with fairly appropriate affect. The mother cried, stating that she was unable to control her son's "gas sniffing." Recently the patient had been leaving the house to sniff gas. They would usually find him some distance away, sitting under a bush, sniffing the gas, gazing up and around, giggling, and talking to himself. They stated that he kept his own hours and had undesirable companions. The parents denied any history of mental illness in the family, but from other sources it was learned that the mother was being seen by a psychiatrist.

Physical Examination

The physical examination was not remarkable. The patient was somewhat short and slender for 15 years of age. He was cooperative though his range of response to questioning was limited and his affect was very flat.

Laboratory Examination

Hematological examinations and liver function tests were within normal limits. X-rays of the long bones and chest were within normal limits. The routine urinalyses were negative, and coproporphyrins were not present in the urine. The EEG was interpreted as normal. A neurological examination was within normal limits. Pulmonary function tests were within normal limits.

Psychological Tests

On the Wechsler Intelligence Scale for Children the patient achieved a verbal IQ of only 70 (which is the lower limit of the borderline defective range) while his performance level of functioning was 92.

Other tests given to him were the Bender-Gestalt and Rorschach tests. In summary, the test findings indicated: 1) there was no evidence of significant deficits in visual motor or non verbal intellectual functioning; 2) there were indications of concentration difficulties as well as sporadic episodes of concrete thinking; and 3) there were strong signs of a definite disturbance at the level of conceptualization.

This third point was supported mainly by the patient's performance on the Rorschach personality test, in which there was evidence of a psychotic degree of personality disorganization. For instance, numerous responses involved such material as animals or humans with parts broken off, black stains on their lungs, stomachs and intestines bursting, etc.

It was thought that the psychological test data in some respects were consistent with a psychosis based upon central nervous system dysfunctioning, but in other respects, there were indications of a schizophrenic process. Thus, it appeared that there were both organic and functional aspects to his illness.

Hospital Course

The patient talked quite readily about his gasoline sniffing in all interviews. One of his major concerns was that it was becoming difficult for him to sniff gasoline at home as his parents had become quite belligerent about this. His idea of getting away from this situation was to marry a rich girl and continue gasoline sniffing. He felt that if he were married his parents would be forced to let him leave. Some of his other ideas were that he would become an artist or a professional boxer, but he had no previous experience with either of these fields. Much of his talk was about religion. He had his own god and did not attend church. Part of his experience with the gasoline sniffing was described as a religious phenomenon, as he would read the Bible and talk to Jesus during these times. After about a week in the hospital, he became quite upset about the teenagers on the unit. He stated that he was not ready to be born on this earth because everything was too modern and too fast. He worried about the wars and the teenagers who did not know any better than to fight. He felt that adults as well as teenagers needed to be straightened out before he would be ready for this world. He became quite depressed after attending some parties on the ward. After about five to seven days of hospitalization the patient complained of a pain in his chest, and feelings of general anxiety. He stated that he needed to smell some gasoline. He was started on Thorazine, 25 mgs. q.i.d., but this did not seem to allay his symptoms appreciatively. At the end of the second week, he, along with another patient, left the hospital without permission. He bought 20 cents worth of gasoline at a filling station near the hospital. He returned to the ward about four hours later in a drunken state, reeking of gasoline. He had influenced his friend also to sniff the gasoline, but this friend did not get the same effect from it that the patient did. The smell of gasoline was strong throughout the ward and even though the patient bathed, his breath smelled of gasoline for the next ten hours. An interview with the patient shortly after he returned from his escapade showed him to be markedly euphoric. This was in marked contrast to his usual rather flat affect. He said that all the doctors had told him the gas would ruin his liver, his chest, and his brain if he continued to smell it, but that they were all wrong, that he was perfectly normal and very smart. It seemed to the interviewer that his vocabulary had increased markedly under the influence of the gasoline. After this experience, the patient seemed to get along a lot better on the ward and he started mixing with some of the other patients.

Movie Was Made

A movie was made of the patient while he was sniffing the gasoline. He instructed us to get a garden hose and a Coca-Cola bottle. The windows of the movie studio were opened because it was felt that the fumes might overpower the physician as well as the patient. However, when the patient demonstrated his method, it was in reality a quite safe technique. He poured the gasoline from the Coke bottle into the hose, rinsed the hose with gasoline, and poured the gas back into the Coke bottle. He then capped both ends of the hose with his thumbs, uncapping the hose briefly to inhale through the hose. During the filming, he became somewhat glassy-eyed and dizzy and appeared to be seeing things in the room and perhaps hearing things, but he would not verify this. After this session, he stated that he would never sniff gasoline again.

Interview With Mother

Toward the end of the patient's hospitalization, another interview was requested with his mother. It was at this time that she revealed the circumstances of the birth of her first two children and the resulting friction between herself and the patient's father. The reason she gave for having the extramarital affairs was that she knew that her husband was also having affairs and she wanted to punish him. She stated that her husband was a drunkard and that she was caught between his drinking and the patient's gasoline sniffing. It was also at this time that she told us that she was seeing a psychiatrist and had a good realization of her problems and of the patient's "mental illness." She also related that while she was pregnant with the patient she had a case of mumps and her doctor advised her to have an abortion. She wondered if this had anything to do with the patient's illness.

Visits to Home

The patient went home on several weekend visits and did not sniff gasoline. Each time the parents reported that he did better socially at home. When

he returned to the ward, he was much more expressive than on admission. The patient had come to realize, he said, that his family and friends did care for him and that he could be one of the family group. He was pleased that his father did not get drunk when he went home. Eventually the patient became quite anxious to go back home and obtain a job, even though he really had no realistic ideas about this. He still thought of becoming a boxer and wanted his father to take him to a ring somewhere so he could practice. He also talked about being a professional bomb disarmer because "they make good money, and with all the civil rights trouble there will be a lot of bombs." He planned to quit sniffing gasoline, but was going to start drinking beer as it would not only make him feel good, but would help make him fat.

The patient was discharged to be followed on an outpatient basis. On his first return visit one month after discharge, he stated that he had inhaled gasoline one time and had been tempted nightly, but thus far had resisted. Although he still had not gone to see his local Vocational Rehabilitation Counselor, as planned, he stated that he wanted some kind of training so he could get a good job. Approximately a week after this visit, the patient's father called several times to relate that the patient was out in his tent, sniffing gasoline, and the NOISE from the gurgling of the gasoline was keeping the patient's mother awake. The father wanted advice on how to stop his son from doing this, mainly from the noise standpoint. The patient himself was unable to come to the telephone as he was, according to his father, seeing things and fighting anyone who came near him.

Since the family lived 200 miles away and they could not seem to cope with this crisis, it was recommended to the parents that they consider commitment of the patient to the State Hospital.

Discussion and Review

The purpose of this paper is to illustrate a typical case of gasoline inhalation. A brief mention of the dynamics is included. The patient was singled out to be a "special" child even before conception. He was the first child fathered in the marital union, as the mother had "acted out" against the father by becoming pregnant by other men twice. In addition, the mother pondered if she should have had an abortion rather than giving birth to the patient. The father manifested dyssocial behavior in his alcoholism and the mother closely identified her son's problem with that of his father. The mother described the father and the patient only in terms of their negative qualities. This attitude on the part of the mother was no doubt responsible for promoting the boy's identification with some of the "bad" traits of his father. It was obvious that there was a parallel between the boy's gas-sniffing and the father's alcoholism, and the patient expressed the possibility of graduating in his identification with his father by stating that if he gave up gas he would then drink beer. The parental rejection is noted throughout the history in that the parents were unable to deal effectively with this boy's behavior even when he was five years old. The extent of parental rejection is well illustrated by the phone call in which the complaint was focused on the noise that the patient was making rather than on the patient.

Similarities With Other Cases

The cases in the literature, as well as the author's case, have certain similarities. All of the cases involved persons under the age of 20 years, the average age at onset being about ten years. The youngest patient reported began the habit at 18 months,[15] and the oldest one began sniffing at age 18 years.[19] The duration of the "sniffing" ranged from two and a half months to 11 years. Most of the sniffers were male in a ratio of 18 males to two females.

There was a high incidence of broken or dyssocial homes in this survey. Some patients were actually in an orphanage,[3, 13] others had been deserted by one or both parents.[3, 10, 15] In some, the difficulties were manifested by extramarital affairs.[2, 13] In some of the cases these liaisons resulted in the birth of additional siblings, such as in the author's case.

Psychiatric Diagnoses Varied

The psychiatric diagnoses were varied, including schizophrenia,[3, 13] schizoid personality,[3, 18] or no psychiatric diagnosis.[7, 10–12] The EEGs were abnormal in two cases,[5, 13] and normal in four cases.[5, 13, 19] In the cases where intelligence tests were done, the IQ on a Wechsler Scale ranged from 75[15] to 122.[13] The neurological examinations were normal in all cases except for those reported by Grant[11] and later Karani,[12] whose patients came to their attention because of peripheral neuropathies.

The intoxication and the neuropathies associated with gasoline inhalation are believed to be produced by volatile hydrocarbons. Though some reports have suggested tetraethyl lead as the cause of the poisoning, Machle[14] states that if careful investigation is done, plumbism is not found. Certainly in the cases reported that have had careful studies for lead intoxication, lead has not been detected.* These tests

** In one case[7] protoporphyrin was detected in the urine. The significance of this isolated finding is not known.*

have included radiological examinations for "lead lines" at the epiphysial joints, studies to determine basophilic stippling in the red blood cells, or urine coproporphyrins. Prolonged exposure to lead is necessary before the development of symptoms of poisoning are apparent. If lead were a factor, stigmata of chronic lead intoxication should have been found in the case of 10 year inhalation reported by Nitsche and Robinson.[15]

In all toxic psychoses the determination of the intoxicating factor is important. The value of a good history is evident. In the acute stage the odor of gasoline is notable. If a peripheral neuropathy is the manifesting disorder, gasoline might not be suspected as the etiological agent unless the physician obtained a prior history of "gas sniffing," or encountered the patient after a gas sniffing episode.

Summary

A case of habituation to gasoline inhalation was presented and the literature reviewed. Various similarities were noted in all patients. All cases occurred in the age group of 20 years or younger and there was a high incidence of males. Psychotherapeutic intervention produced varying results in patients habituated to gasoline inhalation. The results seemed to be related more to the severity of the basic personality structure rather than to the symptomatic behavior.

Acknowledgement is made of contributions to this case by Dr. E. J. McCranie, Dr. L. W. Marshall, Dr. George Longley, and Mr. A. R. Myers.

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The authors describe a large swallowed bone which was successfully removed through the thyroid cartilage.

Foreign Body in the Larynx: A Case Report

JOSE M. ROUCO, M.D., *and*
WILLIAM L. BARTON, M.D., *Macon*

THIS PATIENT is a thirty-five year old white female at the Central State Hospital. She is an imbecile, quite uncooperative, and not able to communicate. The only word that we have heard her say is "Hi." The very fact that she is so mentally retarded may be the only reason she is still alive today, for anyone in her right mind would have gone into such spasm and fear on aspirating such a large foreign body that she would have died.

Present Illness

She was admitted to the Jones Building in severe dyspnea because of a mass in the right side of her neck. She was also having difficulty in swallowing, salivating badly, and there was no previous history of anything similar to this.

Physical Examination

The patient is an under-nourished thirty-five year old white female, uncooperative and mentally retarded, who was unable to give any information. She was in acute upper respiratory distress and unable to swallow. She was salivating, and the left side of the neck was swollen. A mass was felt in the lower left side of the neck anteriorly at the level of the thyroid cartilage. It was extremely tender. There was a dorsal kyphosis. Tachycardia and expiratory rhonchi and wheezes were present over the entire chest wall.

Hospital Course

An emergency tracheotomy was performed by the Resident Staff. She was given Keflin and intravenous fluids. As the patient was unable to swallow after four days, she was taken to the operating room with the impression that she had a large neck abscess. Under sedation and local anesthesia, aspiration of a large amount of pus was made with needle and syringe with some improvement in her condition.

She was seen in consultation by the Department of Otolaryngology three days later in the Jones Building. After much difficulty, an indirect laryngoscopy was done, and a large foreign body was seen filling the larynx, lying just below the level of the vocal cords. She was immediately sent back to the operating room, and under local and general anesthesia, an anterior commissure laryngoscope was passed. With heavy biting forceps and alligator forceps, only small pieces of bone could be removed. The anesthesiologist's laryngoscope was then passed and with a large pair of bandage forceps, the foreign body was grasped firmly. It still could not be removed, and every time traction was made on the foreign body, the left side of the neck would move where the sharp end of the foreign body could easily be palpated.

Following failure to remove the foreign body by endoscopic methods, the neck was painted with Merthiolate and draped. A transverse incision was made at the level of the thyroid cartilage. As soon as the platysma muscle was divided, the sharp end of a large bone was seen. Using sharp and blunt dissection, the incision was carried down to the left thyroid cartilage, and the body of a pork chop bone was then delivered through the thyroid cartilage.

The incision was then closed in layers using # 3-0 Chromic for the deep and superficial fascia and # 4-0 interrupted Black Silk to the skin.

A small drain was then inserted into the incision and a Levin tube was placed in the stomach. The patient was able to swallow the next day, which showed that the esophagus was not damaged. The tube was left in, however, several days for forced feeding. The tracheotomy tube was removed a few days later, and the patient is now back in the ward, her condition satisfactory, with orders to be far more careful as to what kind of diet she will have in the future.

From the Department of Otolaryngology, Central State Hospital, Milledgeville, Georgia.
Presented before the Parkview Private Hospital Staff Meeting, Macon, Georgia.

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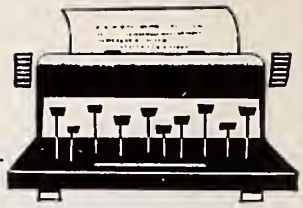

Antimetabolites in the Treatment of Skin Disease

CHEMOTHERAPY FOR MALIGNANT NEOPLASMS is less than two decades old, but in those few years there have been many chemical combinations tried and used to stem the wild overgrowth of epithelial cells.

In this issue there is a report on the topical use on the skin of one of these antimetabolites in which the selective cytotoxic effect of 5-Fluorouracil on the overactive epithelial cell is described.

In general, the use of chemical anti-tumor agents has been considered as hazardous, and they have been seldom used except as a life-saving measure. Indeed a detailed catechism of the possible ill effects, both actual and theoretical, of the antimetabolite is enough to frighten away the physician who may have only a casual interest in problems of malignancy.

Recognizing that there are a number of dermatoses with increased epidermopoiesis which characterize the actinic keratosis, the kerato-acanthoma and including pityriasis rubra pilaris and the more common skin disorder psoriasis, the dermatologist has rated these procedures as reminiscent of oncological disease. Thus, in the past half-decade, it has been shown that the antimetabolites such as 5-Fluorouracil used topically and Methotrexate given orally are effective agents in the treatment of such skin diseases when used with wisdom and selectivity.

The topical use of 5-Fluorouracil as described in this issue of the *Journal,* and previously reported elsewhere by Dellaha,[1] Klein[2] and others, is not accompanied by any general body reaction. While the mechanism of its action has not been clearly defined, the application to the hyperkeratotic skin of actinic keratoses results in a clearly established route of chemical incorporation into the cellular ribonucleic acid and thus acts as a blocking agent in the cellular growth. This apparent specificity of effect, whatever its mechanism, indicates substantial benefits from its application. However, it would be premature even to suggest, much less to believe, that we have a utopian application that will cure skin cancer. 5-Fluorouracil in the proper menstrum, used with circumspection and wisdom, will relieve the disturbing appearance of patients with large numbers of actinic keratoses and this is a chemotherapeutic measure of the first order in the prevention of skin cancer.

The fact that this chemical and also Methotrexate are gaining increasing use for life-ruining forms of skin disease indicates that there are severe forms of skin disease that may be considered "malignant" in the same sense that hypertension may be considered malignant. It also indicates the compelling need for such treatments in special situations and points to a reasonable hope that safer and more effective forms of systemic and local antimetabolites may be evolved in the future.

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2. Klein, Edmund, et al.
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San Francisco Has the Most in June

THIS YEAR'S LARGEST GATHERING of physicians and wives will collect in San Francisco June 16-20, and well they should. That is where they will find the world's most complete medical meeting—complete with scientific sections, exhibits, motion pictures, closed circuit color T.V., plus two other great features: enjoyable social functions with ex-school and classmates, and the excitement and charm of the city itself.

For endless entertainment and worthwhile scientific and business activities, see your *Journal of the A.M.A.*, May 6 issue, for programs and reservation forms.

Hail to the Chief

THE NEW CHIEF of the United States Department of Health, Education and Welfare is Wilber Joseph Cohen, also considered by many to be the chief adversary of the private practice of medicine. Mr. Cohen began to earn this reputation soon after receiving his degree in economics from the University of Wisconsin in 1934. Mr. Cohen became a research assistant to the Committee on Economic Security under President Franklin D. Roosevelt and helped design the Social Security Act in 1934 and 1935. The next 20 years saw Wilbur J. Cohen working in the field of Public Welfare and in 1956 he became a Professor of Public Welfare Administration at the University of Michigan. For four years until being named by President John F. Kennedy in 1961 to the post of Assistant Secretary of Health, Education and Welfare, Cohen maintained a home near Washington and continued to work on Welfare projects there. During that period Cohen wrote the Kerr-Mills bill at the request of Senator Robert F. Kerr (D-Okla.)

Former Senator Paul H. Douglas of Illinois once defined a Social Security expert as "a man who has Wilbur Cohen's telephone number." In view of organized medicine's strong feelings regarding Mr. Cohen the Senate confirmation hearings should be interesting to say the least.

Edwin F. Smith

EMORY TO MEASURE EFFECTS OF EXERCISE ON LUNG DISEASE

How does exercise help the person with chronic lung disease?

A three-year study by Emory University School of Medicine is designed to find out. Emory has received a $106,863 grant from the U. S. Social and Rehabilitation Service to study physical therapy in chronic pulmonary disease.

The study is designed to determine the "actual physical working capacity" of a person with chronic obstructive lung disease. This will provide a quantitative measure of the effects of physical therapy.

The investigators are seeking indications from low level steady state exercise—such as walking slowly on a treadmill. This type of exercise is designed to be largely free of influence from the patient's motivation and his state of physical training.

The project will also include special studies of respiratory tract secretions. Studies will be made of the chemical and physical properties, as well as the bacterial population, of sputum.

A POLITICAL CREED

WHAT IS A CREED? According to Webster it is a summary of principles or beliefs to which one subscribes. If worthy of the name it must be timeless, demanding, immutable.

Appearing elsewhere in this issue of the *Journal* is a statement entitled "My Political Creed." It is a reminder of the hard won, and still harder to maintain, freedoms that each of us enjoys as a citizen and as a practicing physician. It reminds us of a great deal more too.

It reminds us that the defense of freedom is a solemn obligation; that everything we now have is ours because our predecessors were diligent in that defense; and it reminds us that we can be no less diligent if we hope to pass on to our children the heritage of a free society.

The fundamental freedom, the one which must preceed all others in a republican form of government, is freedom to participate in the political process. For it is through this process that the degree of freedom we shall have in religion, speech, press, ownership of property and all the rest, is determined.

The mere right to participate in the electoral process, however, unless that right is fully exercised, will guarantee nothing; intelligent, informed and effective participation in the process by which we elect our lawmakers will.

The Georgia Medical Political Action Committee knows that physicians are intelligent and informed participants in the requirements of citizenship. The GaMPAC role, therefore, is to help them become effective participants, effective through organized political activity.

There may be other ways to be politically effective to the full extent of one's capacity, but nobody has yet explained a better way.

Charles R. Andrews Jr. M.D.

Charles R. Andrews, Jr., M.D.
President, Medical Association of Georgia

PROGRESS REPORT ON CANCER PROGRAM, GEORGIA REGIONAL MEDICAL PROGRAM

ROBERT R. SMITH, M.D., ***Atlanta****

THE OBJECTIVES OF THE CANCER PROGRAM of the Georgia Regional Medical Program are to reduce suffering, disability and death from cancer by promoting the opportunity for physicians to be competent in the detection and treatment of cancer and for patients to receive the benefits of the latest advances in the diagnosis and treatment of cancer.

It is estimated that there are over 13,000 new cancer patients each year in Georgia, resulting in more than 5,000 deaths, immeasurable pain, suffering and hardship and a minimum economic loss to the citizens of Georgia of over twenty-six and one-half million dollars each year. To help meet this need, the Regional Medical Program's cancer task forces have developed an operational grant request to implement a cancer program for the State of Georgia.

Area Facilities Planned

This program is built around: 1) *Area Cancer Facilities* to provide effective total care of the cancer patient throughout the state within a reasonable distance of his home; 2) *cooperative arrangements to support cancer programs* in hospitals which have a sufficient number of new cancer patients per year to allow competent professional personnel to develop and maintain their skills as well as add to the basic knowledge of the cause and cure of cancer; 3) providing a group of knowledgeable physicians who will maintain a program of *continuing education* for medical and allied health personnel in the area; 4) *supporting workshops* on the specific subject for professionals specializing in the area of the diagnosis and treatment of cancer; 5) providing the opportunity for *consultants* to visit the clinics for teaching consultations on specific patients and to encourage the clinics in *self audit* and *evaluation* of end results; and 6) building and maintaining a *state-wide tumor registry* centered in the Area Cancer Facilities throughout the state to provide physicians treating cancer patients knowledge as to the changing demographic patterns of cancer and the results of their method of therapy.

Area Facilities to Administer Programs

The Area Cancer Facilities will be designated as those which meet the requirements of the American College of Surgeons Commission on Cancer. Part-time support of the Director of these facilities has been requested to allow them to administer the area program of continuing education, to conduct tumor clinics and/or conferences, to arrange for visiting teaching consultants, and to maintain the tumor registry for that area. Support for the local tumor registry secretaries, registry supervisors, follow-up methods, data processing and evaluation is also included in the grant request.

* *Dr. Smith is Associate Director of the Georgia Regional Medical Program.*

The professional education program is built around the use of teaching consultants, workshops and the regional development of educational television and/or taped teaching programs. The grant also contains a request for support of a program of public education in conjunction with the American Cancer Society, built around spot radio broadcasts of information regarding cancer prevention and detection.

Funds for facilities are not included in this year's grant request; however, the program does anticipate the need for the development of terminal care facilities in association with the area cancer facilities. The entire program has built into it a program of evaluation which will allow measurement of the effectiveness of the program.

938 Peachtree Street

SESSIONS ON AUTO ACCIDENTS, HEALTH CARE PLANNING AMONG PROGRAMS AT AMA ANNUAL CONVENTION

Four general scientific meetings of wide medical interest will be included in the Scientific Program of the American Medical Association's 117th Annual Convention to be held in San Francisco June 16-20.

The four general sessions are:

Automobile Accidents, with participation by Sections on Orthopedic Surgery, General Surgery, Pediatrics, Physical Medicine, and Preventive Medicine, as well as the AMA Committee on Medical Aspects of Automotive Safety.

Health Care Planning, with participation by Sections on Preventive Medicine, Diseases of the Chest, General Practice, General Surgery, Internal Medicine, and Military Medicine.

Management of Infectious Diseases, with participation by Sections on Experimental Medicine and Therapeutics, Allergy, Diseases of the Chest, General Surgery, Pediatrics, and Preventive Medicine.

Treatment of Advanced Malignant Disease, with participation by Sections on General Surgery, Gastroenterology, General Practice, Internal Medicine, Nervous and Mental Diseases, Pathology and Physiology, Colon and Rectal Surgery (formerly Proctology), and Radiology.

Regular scientific programs also will be presented by each of the 22 Scientific Sections, plus a program by the Section on Miscellaneous Topics. The latter program will include a full day session on smoking and health sponsored by the AMA Committee on Research for Tobacco and Health, and a full day session on neurological surgery in which the American Association of Neurological Surgeons will participate.

The entire scientific program will appear in the May 6 issue of the *Journal of the American Medical Association.*

The youngest exhibitors and official guests of the AMA at its Annual Convention will be two teenage high school scientists.

They will be chosen at the 19th International Science Fair in Detroit May 15-18 by members of the AMA Council on Scientific Assembly. Competing with over 400 other finalists from every state and several foreign nations, the two top AMA winners will be named for the excellence of their studies and exhibits in the basic medical sciences.

During the Convention, they will exhibit their displays in the Scientific Exhibit and will be introduced as honored guests of the AMA to the House of Delegates, the Woman's Auxiliary to the AMA, and at the Scientific Awards Dinner.

The AMA has been participating in the International Science Fair for 13 years as part of its program to attract superior students to the study of the medical and health sciences.

INDICATIONS FOR VASCULAR SURGERY IN OCCLUSIVE ARTERIAL DISEASE

WILLIAM H. MORETZ, M.D., *Augusta*

SPURRED BY THE DESCRIPTION by LeRiche in 1948 of the syndrome produced by thrombotic occlusion of the terminal aorta, tremendous progress has been made in reconstructive surgery on arteries leading to and in the extremities. Best results follow surgery for aorto-iliac occlusive disease. The results of reconstructive arterial surgery in the femoro-popliteal area, though not as good as in aorto-iliac disease, are highly satisfactory in many patients. Because surgery is so often followed by marked improvement, enthusiasm for this type of surgery has been justifiably great.

When to Perform Surgery

To be surgically correctible, there must be a good outflow distal to the area to be corrected, and, as emphasized more recently, there must be an adequate inflow to the area to be corrected. However, the mere presence of a surgically correctible arterial occlusion does not imply that arterial surgery should be performed. This conclusion becomes more obvious when the late postoperative course of these patients is compared with the course of patients with similar but non-operated-upon arterial lesions, and is particularly true in those with only mild symptoms and in those with significant occlusive arterial disease elsewhere. Mild symptoms may remain mild for years or may even improve, whereas occlusions elsewhere may occur or may progress and overshadow the original occlusion in importance.

The decision for or against surgical correction is not difficult in the majority of patients. The decision for operation is easy in those who have incapacitating symptoms, rest pain, or imminent gangrene in the presence of a readily correctible lesion and no severe contraindication to surgery. The decision against operation is easy in those with mild symptoms, no threat of gangrene, and a severe contraindication to surgery, even though the arterial lesion is surgically correctible.

Factors in Deciding on Surgery

In many patients, however, the decision is difficult and requires very careful weighing of many factors. Prerequisite is a complete workup, including an evaluation of function of the heart, kidneys, and brain. Questions which will affect this decision include:

1) How bad are the symptoms? Is claudication severe, with onset after walking only a short distance? Does the pain interfere with his work, slightly or severely? Or does it only irritate him by interfering slightly with his golf?

2) What is the outlook for the extremity if surgery is not performed? Will the limb be lost because of gangrene, severe rest pain, or an ulcer which will not heal?

3) How good are the chances of helping the limb by operation? Are irreversible changes present which rule out complete salvage? Is the condition of the arteries above and below the occlusion barely acceptable or are those arteries in very good condition? Will a lesser procedure suffice?

4) Is the patient's general condition such that a salvaged extremity will restore him to active productive life or are other limitations present which preclude his

using the salvaged extremity? Is there vascular or other disease elsewhere which is life threatening or which would make operation very hazardous?

Period of Observation Valuable

A period of observation is often helpful in making a decision when the need for early surgery is not clear. During this period of observation we have been impressed, and often pleasantly surprised, with the value of cessation of smoking and a program of increasing walking exercises. In some, the improvement has been sufficient to allow them to live a comfortable and pleasant life. Others have improved, or at least become no worse, until progression of disease elsewhere led to infarction of the myocardium or brain or to renal failure. Still others have shown no improvement or have become worse, making the decision for surgery more clear.

For many patients in whom the wisdom of surgical treatment is not clear, a period of observation and conservative management can be most helpful.

Medical College of Georgia

HIGHLIGHTS OF EXECUTIVE COMMITTEE MEETING, MARCH 16, 1968–ATLANTA

This summary is being published so that the MAG membership may be advised in brief of the actions of the Association's Council and Executive Committee. It covers only major actions and is not intended as a detailed report. Full minutes of these meetings are available upon any member's request to the MAG Headquarters Office.

Hart County Hospital Staff request, embodied in a resolution from Elbert-Franklin-Hart Medical Society, was reviewed and a motion was passed asking the MAG Hospital Activities Committee to look further into the matter.

The Ad Hoc Committee on Employment of a Physician for MAG presented its report in detail. Their conclusion was that it was not feasible to take this action at this time, but that the idea should be reevaluated periodically.

Physician Utilization Project Under Title XIX was reviewed and the Executive Committee voted that the State Department of Public Health, carrier for Title XIX, be officially notified of MAG's willingness and interest in assisting in the review mechanism of all phases of utilization procedures in Title XIX program pursuant to a contract whereby MAG will be reimbursed any costs it may have in carrying out its responsibilities.

Method of Military Medicare Case Review was modified by the Executive Committee to provide that the Medical Review and Negotiating Committee will function as a state level Appeal Board. The Executive Committee will continue to function as the final Board of Appeal.

Attorney General Arthur Bolton's Ruling regarding prescription drugs by other than doctors of medicine was reviewed by Attorney William B. Spann. Mr. Spann was authorized to continue along with John Moore to pursue his investigation into the feasibility of entering into litigation to clarify the matter. Mr. Spann and Mr. Moore will meet with the Attorney General to determine what avenue of litigation will be followed.

Other Actions of the Executive Committee Were:

—Approved a list of members to receive Certificates of Appreciation from MAG.

—Expressed an interest in the idea of holding a Committee Conclave, a weekend during which all MAG Committees would meet.

—Reaffirm MAG policy of encouraging physicians to seek opportunities to serve on the Governing Boards of Hospitals.

—Asked the President to explore with officials of the Medical College of Georgia the status of MAG's Talmadge Hospital Liaison Committee and the need for its continuance.

—Instructed the Executive Secretary to invite the Presidents of adjacent State Medical Associations to attend the MAG Annual Session as a fraternal delegate, and be recognized at the House of Delegates and to invite the Presidents of the two Student AMA Chapters in Georgia to attend and be recognized in the House of Delegates.

—Decided to allow the Regional Auditor of the Department of Defense the temporary use of a Headquarters Building parking space.

—Voted unanimously to reappoint Dr. C. Daniel Cabaniss as an MAG representative on the Interprofessional Council of Georgia, and endorsed the proposal to increase the size of the Interprofessional Council by adding another Doctor of Veterinary Medicine.

—Expressed an interest in the Columbus Blue Cross-Blue Shield Plan's new schedule of allowances.

—Determined that the next meeting would be held at MAG Headquarters, Sunday, April 7, 1968.

NEW MEMBERS

James H. Blair, Jr. Active—Stephens	800 E. Doyle St. Toccoa, Ga. 30577
Ted D. Cash Active—Carroll-Douglas-Haralson	Bankhead Highway Tallapoosa, Ga. 30176
George B. Crisp Active—Fulton	1293 Peachtree St., N.E. Atlanta, Ga. 30309
Bruno Denis Active—Fulton	3441 Stewart Ave. Hapeville, Ga. 30054
Marshall F. Eidex DE-4—DeKalb	3500 Edenborn Ave. Metairie, La. 70002
Maxwell A. Eidex DE-4—DeKalb	1427 St. Marys Blvd. Jefferson City, Mo. 65101
Edgar J. Filson Active—Georgia Medical Society	9 Medical Arts Center Savannah, Ga. 31405
Julio D. Hernandez Active—Fulton	490 Peachtree St., N.E. Atlanta, Ga. 30308
Channing S. Jun Active—Ocmulgee	201 Foster St. Eastman, Ga. 31023
Orlando O. Lopez Active—Fulton	401 Peachtree St., N.E. Atlanta, Ga. 30308
F. M. Macias Active—Spalding	604 S. 8th St. Griffin, Ga. 30223
Ralph H. Massengill Active—Fulton	3180 Atlanta St., S.E. Smyrna, Ga. 30080
Hubert I. Matthews Active—Thomas-Brooks	900 Gordon Ave. Thomasville, Ga. 31792
W. Brem Mayer, Jr. Active—Fulton	1365 Clifton Rd., N.E. Atlanta, Ga. 30322
Robert L. McDonald Active—Fulton	3390 Peachtree Rd., N.E. Atlanta, Ga. 30326
William A. Miller Active—Georgia Medical Society	15 Bransby Dr. Savannah, Ga. 31406
Frank G. Osborne Active—Thomas-Brooks	414 Gordon Ave. Thomasville, Ga. 31792
Robert K. Paul Active—Muscogee	1444 4th Ave. Columbus, Ga. 31901
Robert B. Quattlebaum, Jr. Active—Georgia Medical Society	9-A Medical Arts Center Savannah, Ga. 31405
Albert H. Robinson Active—Fulton	47 Trinity Ave, S.W. Atlanta, Ga. 30334
Daniel W. Rose Active—Georgia Medical Society	17 Medical Arts Center Savannah, Ga. 31405
Robert G. Selker Active—Fulton	1365 Clifton Rd., N.E. Atlanta, Ga. 30322
Joseph T. Stubbs, Jr. Active—Georgia Medical Society	717 East 65th St. Savannah, Ga. 31405
John O. Whitehurst Active—Fulton	1365 Clifton Rd., N.E. Atlanta, Ga. 30322
Sparkman H. Wyatt Active—DeKalb	315 W. Ponce de Leon Ave. Decatur, Ga. 30030

SOCIETIES

The March meeting of the **Bulloch-Chandler-Evans Medical Society** was concerned with the relationship of the minister and the doctor in the treatment of the "whole" patient. Over sixty doctors, ministers and their wives met at the Holiday Inn in Statesboro for the meeting.

The **Seventh District Medical Society** met April 3 at the Coosa Country Club in Rome as guests of the **Floyd County Medical Society.** Four scientific speakers were followed by social hour and dinner. Drs. Lambros Regas, Lester Harbin, Eduardo Montana, and Ralph Howse addressed the meeting.

The **Randolph-Stewart-Terrell Medical Society** met March 12 at Metts' Lodge in Dawson for the election of officers. Carl Sills was elected president, Mack Allen vice president, John Bates secretary-treasurer and Earl Mayo program chairman.

Dr. Archer Moore discussed Minimal Brain Damage and Minimal Brain Disfunction at the February meeting of the **Bibb County Medical Society.**

At the February meeting of the **DeKalb County Medical Society,** the members heard Mr. Moshe Shoshani, Director of the Southern Region Israel Government Tourist Office, speak on "Israel, the Holy Places and the Status Quo."

Edward Loughlin presented a paper on "Immediate Prosthetic Settings Following Amputation" at the March meeting of the **Hall County Medical Society.**

The **Fulton County Medical Society** sponsored the 25th annual Atlanta Graduate Medical Assembly April 15-17. Sixteen nationally prominent physicians from across the country conducted courses in several specialties.

Kenneth Whitaker, special agent in charge of the Savannah FBI office, was the keynote speaker at the

Georgia Medical Society's program on "The Rebellious Teenager" March 12.

The **Muscogee County Medical Society** held a panel discussion on "Self-Employed Individuals Retirement Plans" at its March meeting at the Harmony Club in Columbus. The society also sponsored a course on procto-sigmoidoscopy in conjunction with the Muscogee County Chapter of the American Cancer Society on March 23 at Callaway Gardens.

PERSONALS

Third District

A. J. Kravtin of Columbus discussed the ill effects of L.S.D. and other drugs in an article in the *Columbus Enquirer.*

Fifth District

Among the new officers of the Emory University Medical Alumni Association are **J. Hagan Baskin, Jr.,** Atlanta, vice president; **William L. McDougall Jr.,** Atlanta, secretary-treasurer, and **J. Frank Walker,** Atlanta, trustee.

Wyman P. Sloan of Atlanta was awarded a golden anniversary diploma by the Emory University Medical Alumni Association marking 50 years of service to humanity since his 1918 graduation.

James J. Corrigan, Jr., of Atlanta discussed "Intravascular Clotting Defects Associated with Infection" at the meeting of the American Academy of Pediatrics in Atlanta in March. Among the Atlanta physicians taking part in the meeting, in addition to Dr. Corrigan, were **Joseph H. Patterson, Richard W. Blumberg, Sidney Breibant, Brit B. Gay, Andre Nahmias,** and **James F. Schwartz.**

Edgar Boling of Atlanta attended the 14th annual doctor-nurse meeting of the American College of Surgeons in Williamsburg, Virginia, in February.

J. Gordon Barrow of Atlanta discussed the proposed projects of the Georgia Regional Medical Program before the 40th annual meeting of the Georgia Hospital Association in late March.

New president of the Atlanta Blue Shield Plan for Physicians Services is **Edwin C. Evans.**

Sidney Olansky of Atlanta was visiting professor and guest lecturer at the Medical College of Virginia on March 12. He also made hospital rounds at the Richmond hospital. On March 28, he was visiting professor and guest lecturer at the Lexington Clinic in Lexington, Kentucky.

Sixth District

Tom Ross of Macon was guest speaker at the Eastman Pilot Club in February. He explained the administration of artificial respiration in an emergency. **Frank Holder** of Eastman introduced Dr. Ross.

Charles O. Walker has recently joined **Earl Lewis** and **Morris Brown** in the private practice of surgery in Macon. Dr. Walker has just completed his military obligation.

Seventh District

Charles R. Underwood of Marietta is the new president of the Emory University Medical Alumni Association.

Luther Fortson of Marietta has been named to the Cobb County Mental Health Committee.

Rome orthopedic surgeon **James M. Kelly** spoke to the Rome Bar Association in March on "Doctors, Depositions, Evidence, etc."

Eighth District

Donald Stecker of Lakeland attended a three-week training course in San Antonio, Texas, in March.

John E. Penland of Waycross, a 1918 graduate of the Emory University Medical School, received a golden anniversary diploma from the alumni in recognition of 50 years of service to humanity.

Ninth District

C. Markham Berry of Ellijay was featured in an article in the *Atlanta Journal and Constitution* in March as a small town general practitioner who finds family practice a rewarding life.

Gainesville physician **Martin H. Smith,** state chairman of the Georgia Chapter of the American Academy of Pediatrics, presided as the session chairman at the annual spring meeting in Atlanta in March.

Tenth District

Members of the Augusta Exchange Club heard **Robert G. Ellison** discuss heart transplants at a meeting in March.

Alex Murphy of Augusta was an official delegate of the Georgia Society of Internal Medicine to the 12th annual meeting of the American Society of Internal Medicine in Boston in March.

Rufus Payne of Augusta spoke before the annual meeting of the Augusta Area Tuberculosis Association in March.

DEATHS

Frank Rambo Mann

Frank Rambo Mann, 83, a prominent practicing physician in McRae for more than forty years, died February 23, 1968, in the Telfair County Hospital.

Dr. Mann attended the University of Georgia, graduated from the Atlanta Medical College and Emory University and did post-graduate work in eye, ear, nose and throat in New York. He was a member of the American Medical Association, the Medical Association of Georgia, and American Academy of General Practice, and the Southern Medical Association.

Dr. Mann is survived by his wife, the former Zilla Elder of Lumber City; one daughter, Mrs. Marion W. Luckie of Harlem; three sons, Edmund Mann of Oak Ridge, Tennessee; Frank Mann, Jr., and R. E. Mann of McRae; and one sister, Mrs. O. B. Burch of Jacksonville.

Franklin Brown Pickett

Franklin Brown Pickett, 95, of Tifton, a pioneer physician in Southwest Georgia, died March 1, 1968, at Tift General Hospital.

Dr. Pickett, who still saw patients after 71 years of practice, began his practice in 1897 in Ty Ty. He served as a member of the Tift County Board of Education for 16 years and was mayor of Ty Ty for 30 years.

He received a 50-year pin from the Medical Association of Georgia in 1947, and in 1957, he was named "General Practitioner of the Year." He was presented the Award of Merit by the Medical College of Georgia in 1967.

Dr. Pickett's wife and three children preceded him in death and he is survived by several nieces, including Miss Katie Ruth Pickett of Tifton, with whom he resided.

WHAT PRICE GLORY?

To the Editor:

Perhaps without enough factual knowledge I am expressing an individual opinion, denied no one. I am sure others are doing so with increasing concern and conviction. Also the privilege, right or wrong, of any thinking and involved American to sincerely express some agonizing feelings regarding the situation in Viet Nam and Korea.

The Viet Nam situation is an unfortunate inheritance of our President. Probably our intelligence service and proper future protection of our naval ships should have closer consideration.

We had one experience of the bomber over Russia several years ago; dishonestly denied it—then admitted it! Being so, why not admit a possible error with the "Pueblo"? Is there any positive, undeniable proof that some error could not have been made? Regardless of intelligent use of accepted instrumental technology or worthy seamanship, a ship, without intention or knowledge, may cross an invisible or otherwise faint line between regulations and reality?

Why not admit a possible error, apologize and seek the return of our men and possibly the vessel, rather than by stubborn insistence further provoke the mounting antagonism of South Korea, with destruction of property and loss of our and their best young men.

An English businessman of worthy intelligence and acumen has suggested that our government ask the U.N. to intervene for the United States, primarily in the Viet Nam chaotic catastrophic situation.

There, thousands of innocent civilians are maimed or killed, many farms with necessary food supply destroyed, denying survivors; the temples of theological, sentimental and historic value forever destroyed. Even if a military victory should ensue (not likely with Soviet and Chinese support and non-cooperation from Laos and Cambodia), the lands and resources will be further destroyed, with "parched earth" residue affecting the health, morale and hopes of a people we are supposedly trying to help.

We may be willing and able to help reconstruct and restore (over many years) some of the damage by the enemy and us, but their suffering will not be relieved, while we endure their everlasting condemnation.

We have been asked by many of our "friends" to take another searching look into this perplexing situation. We have already lost "face" with many nations of the world.

A request to the United Nations to have that body plead, in the sense of human fairness, fact and dignity, to cease this painfully demonstrated useless further destruction of lives and property and to affirm that the time has come to cease fighting, and as soon as with reasonable safety, withdraw our military, but not rehabilitation.

If we will agree, and we should, we will have then made an able contribution to peace and to an effort to save our "face," which unfortunately is in jeopardy. When this untenable hold of our position is at last, though, by some, stubbornly realized, we may then renew our attention to the restoration of publicized standing in world affairs, using our means in, and our devotion to, commendable reconstructive effort.

Having spent three years in the medical corps of the U.S. Army during World War I, in France and Germany, I know something of the tragedies and aftermath of war. Then, our nationwide efforts were in a different (protective) cause, with very few "objectors."

I anticipate these remarks, which assures me that you have read them, will be met by many "mere folly," "pacifist," etc. I believe sincerely that we will have to reassess our position, come off our "high-horse" and "never lost a war" attitudes, and honestly and courageously face realism and cold painful facts.

P. O. Chaudron, M.D.
Colonel, Medical Corps, U.S. Army, Inactive

Vacation trip....

Motion sickness?

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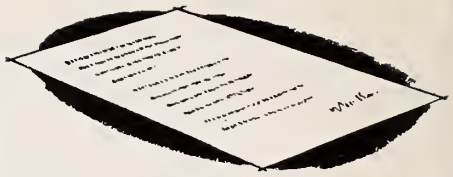
ABSTRACTS BY GEORGIA AUTHORS



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Twenty-one pregnant women, gestation age between 18-40 weeks, who were eventually delivered of stillborn infants constitute the basis of this report. Amniography was performed by the transabdominal approach injecting 30-50 cc of sodium and meglumine diatriazoates after fetal death was confirmed (absence of swallowing); patients were observed for the onset of labor. All patients delivered within seven days following amniography. In three, labor was induced with a dilute infusion of oxytocin. In another three patients labor was augmented with oxytocin. The average time between amniography and the onset of labor was 35.5 hours. The average length of labor was 10.2 hours. The success rate of 81 per cent in the present series suggests that amniography may be a useful procedure to terminate pregnancies in which fetal death has occurred.

Moss, C. Wayne, and Cherry, William B., National Communicable Disease Center, Atlanta, Ga., "Characterization of the C15 Branched-Chain Fatty Acids of Corynebacterium acnes by Gas Chromatography," J. Bacteriology 95:241-242(January)1968.

Gas-liquid chromatography was used to determine the point of branching (iso- or anteiso-) of the single methyl group in the C_{15} branched-chain acids which were reported previously to occur in relatively large amounts in *Corynebacterium acnes* and certain *Propionibacterium* species (C. W. Moss, et al., J. Bacteriol. *94:*1300-1305, 1967). All strains studied were processed under uniform conditions after cultivation in a single growth medium. Analyses were made on a 2.4 m × 5 mm U-tube glass column of 15 per cent ethylene glycol succinate. Each of 22 isolates of *C. acnes* uniformly contained iso-C_{15} acid as the single most abundant acid with smaller amounts of anteiso-C_{15} acid. The ratio of iso-C_{15} to anteiso-C_{15} was approximately 7:1. A similar ratio of iso-C_{15} to anteiso-C_{15} acid was also observed in two ATCC cultures of *Propionibacterium acnes* (ATCC 6919 and 6921). In contrast to the results with the *C. acnes* and *P. acnes* cultures, the single most abundant acid in the single strain of *P. freudenreichii* (ATCC 6207) and *P. shermanii* (ATCC 9614) was anteiso-C_{15} acid. The ratio of iso- to anteiso-C_{15} acid in these two strains was approximately 1:8.

Izenstark, Joseph L., M.D., and Lafferty, Walter, B.S., Emory University School of Medicine, Atlanta, Ga., and Tulane University School of Medicine, New Orleans, La., "Medical Radiological Practice in New Orleans: Estimates and Characteristics of Visits, Examinations, and Genetically Significant Dose," Radiology 90:229-242(February)1968.

A prospective universal x-ray data collection study was performed in New Orleans during 1962-1963. Patient and x-ray technical data were collected from 73 per cent of the x-ray units in use in the area in 144 locations. Each unit was observed for a four week calendar period and data were recorded at the time of the x-ray exposure.

Annual estimates on x-ray usage were determined and are presented in several tables and figures illustrating the distribution of various examinations amongst practices and for various ages and both sexes. Sixty per cent of the roentgenographic work was performed in hospitals. Radiologists supervised 75 per cent of the examinations. Specialists performed only one to two per cent of the examinations peculiar to their specialty. Radiologists generally made more projections per examination than non-radiologists, but used smaller x-ray fields.

A mathematical model was developed which used the technical data to derive skin and gonad exposures. The genetically significant dose for New Orleans was calculated as 75.3 mR (males 31.5 mR; females 43.8 mR). One-third of this dose was due to obstetrical examinations. The poor use of collimators also contributed significantly to the dose.

All groups of practitioners had unnecessary exposure for specific examinations. A re-evaluation of radiographic techniques and the indications for some examinations is needed.

Witham, A. C., M.D., Rainey, R. L., M.D., and Edmonds, J. H., Jr., M.D., Medical College of Georgia and Eugene Talmadge Memorial Hospital, Augusta, Ga., "Prediction of Right Ventricular Pressure in Pulmonic Stenosis From Sponge Vectorcardiogram and Electrocardiogram," Am. Heart Journal 75:186-199(February)1968.

The Helm sponge VCG lead system has been tested in a study of 21 patients with isolated pulmonary stenosis. Correlations between 7 hemodynamic, 70 VCG, and 10 ECG parameters have been scanned. From these, the best correlations have been presented and include 4 hemodynamic, 12 VCG, and 4 ECG measurements. Right ventricular peak pressure shows the highest correlation with VCG measurements. The best is with the spatial sum of the terminal (S) vectors ($r = 0.90$), but prediction of right ventricular pressure, particularly in severe stenosis, can be significantly improved by use of a multiple regression equation utilizing 3 VCG and 1 ECG variable ($r = 0.94$).

The development of the major changes of the QRS loop with concentric hypertrophy is seen to be a continuum, gradually disclosing the activation sequence of the right ventricle. The S vector simultaneously increases its voltage, swings anteriorly, and occurs earlier. Changes in the R vector are not linearly related to increasing pressure over the entire range but are evident in the severe cases in which R becomes anterior, earlier, smaller, and may disappear completely.

Brown, Faith K., M.S., Brown, Walter J., M.D., Ellison, Robert G., M.D., and Hamilton, William F., Ph.D., Medical College of Georgia, Augusta, Ga., "Electrocardiographic Changes During Development of Right Ventricular Hypertrophy in the Dog," Am. J. Cardiology, 21: 223-231(February)1968.

Twenty-six mongrel dogs were operated on to produce volume overload of the right ventricle. Thirteen of these had only pulmonary valvular insufficiency produced by excision of the valve cusps. The other thirteen had, in addition to valvular insufficiency, surgically produced shunts which tended to augment the right ventricular volume loads. All were studied for progressive electrocardiographic changes over postoperative periods as long as 4.5 years. Right ventricular hypertrophy was evaluated at autopsy. Progressive electrocardiographic changes were observed in (1) an increasing ratio of R wave voltage to that of the total RS excursion in V_1 (designated "V_1 index"); (2) RS configurations, which appeared progressively farther toward the left side of the chest in the V leads; and (3) the earliest vectors of depolarization, which shifted toward the sternum or left anterior quadrant of the chest. No progressive changes were observed in direction of the QRS axis, duration of the QRS complex, voltage or duration of the R wave, time of onset of intrinsicoid deflection, S-T segment, T wave or P wave. Hemodynamic and electrocardiographic findings are presented in graph form and their diagnostic usefulness is discussed.

From the Departments of Physiology, Medicine, and Surgery of the Medical College of Georgia, Augusta, Ga. This study was supported by the Life Insurance Medical Research Fund and Grant HE-00240 from the U.S. Public Health Service.

Sekulic, Srboljub M., M.D., Hamlin, James T., III, M.D., Ellison, Robert G., M.D., and Ellison, Lois T., M.D., Medical College of Ga., Augusta, Ga., "Pulmonary Surfactant and Lung Circulation in Experimental Atelectasis," Am. Rev. of Respiratory Disease, 97:69-75(January)1968.

An investigation was undertaken to determine the relationship between changes in lung circulation and pulmonary surfactant after experimental atelectasis produced by bronchial occlusion or pulmonary artery ligation. Surfactant studies were done in conjunction with measurements of pulmonary blood flow through the atelectatic lung after bronchial occlusion, and of bronchial collateral blood flow after pulmonary artery ligation for a period of one to 30 days. Uncomplicated obstructive atelectasis after bronchial occlusion was not associated with surfactant abnormalities, although pulmonary blood flow decreased to about 15 per cent of the cardiac output. Congestive atelectasis developed during the first days after pulmonary artery ligation, together with surfactant deficiency and decrease of blood supply to the lung to less than 5 per cent of cardiac output. One month later, when collateral bronchial circulation was about 20 per cent of cardiac output, surfactant studies were within normal limits and atelectasis was no longer present. The findings suggest that pulmonary blood flow after bronchial occlusion, and bronchial collateral blood flow one month after pulmonary artery ligation, are sufficient for synthesis of surfactant.

Hollis, Dannie G., Wiggins, Geraline L., and Schubert, Joseph H., National Communicable Disease Center, Atlanta, Ga., "Serological Studies of Ungroupable Neisseria Meningitidis," J. Bacteriology 95:1-4(January) 1968.

Verification that Slaterus' *Neisseria meningitidis* serotypes X, Y, and Z are groups distinct from each other and from groups A, B, C, and D was made by use of the tube agglutination test on absorbed and unabsorbed antisera. A significant number of meningococcal strains in this country, which could not be classified serologically with standard antisera prepared to Branham's neotype A, B, C, and D strains, were grouped specifically with antisera prepared to the Slaterus types. The strains grouped as X, Y, and Z were from various geographical areas of the United States and were isolated from both carriers and cases. Over a 2-year period, the cultures tested ranged in predominance in descending order as follows: group B, C, Y, X, Z, A, and D. It is recommended that Slaterus' types should be considered as standard groups and follow in alphabetical order with the standard A, B, C, and D groups; i.e., X would be designated as group E, Y as group F, and Z as group G. It was observed that false-grouping cross-reactions could be greatly reduced by reconstituting the lyophilized grouping antisera in 50 per cent glycerol-water. Of 99 cultures which could not be specifically grouped with antisera reconstituted in distilled water, 19 were specifically grouped with antisera reconstituted in 50 per cent glycerol-water.

Beard, Belle Boone, Ph.D., Social Science Research Institute, U. of Ga., Athens, Ga., "Some Characteristics of Recent Memory of Centenarians," J. of Gerontology 23:23-30(January)1968.

This paper is a segment of a larger study of cognitive functioning of some 700 people ranging in age from 100-123 years. This sample consists of 62 men and 104 women roughly representative of the age, sex, race, and nationality categories in United States population. The purposes were to test two popular hypotheses: (1) memory declines with age and (2) recent memory declines more than remote memory; and to seek to discover correlates of recent memory. Subjects were tested on retention and recall of names, WAIS digits, recent events, ability to remember and follow instructions (as on Trail-Maker Test, HTP, Digit symbols and other tests); ability to remember steps in a sequence, etc. Results were correlated with social and demographic data. Centenarians tend to retain and to be able to recall practical information better than standard test exercises that have no reality for them. Test performance was better when Subject verbally repeated instructions before beginning. Memory both for abstract and concrete information is significantly correlated with education, mental status and past experience in use of memory. Males performed better than females on the digits-backward test and ability to name present President of the United States. Surprisingly, people over 103 showed better memory of recent events than people 100-103. Recent memory scores showed high correlation with ability to recall historical events, to recite songs and poetry, and to interest in politics. No age limits were discovered for ability to retain or to recall recent "in put."

Campbell, Wallace G., Jr., M.D., Emory University School of Medicine, Atlanta, Ga., "Synovial Fine Structure and Permeability After Intra-articular Nitrogen Mustard," Archives of Pathology 85:162-174 (February)1968.

After intra-articular injection of a rabbit knee joint with 1 mg. of mechlorethamine hydrochloride (nitrogen mustard), the entire synovium and the adjacent subsynovium undergo necrosis. By 24 hours after the intra-articular injection, all the cells of the synovium have undergone lysis and the permeability of the joint capsule to Thorotrast is increased. By three days after the intra-articular injection, a membrane of electron dense material covers much of the joint lining. This membrane has tinctorial and immunochemical properties like fibrin. Ultrastructurally it appears as an electron dense membrane that contains microfibrils and cellular debris, and it bears little resemblance to fibrin clots. This membrane is virtually impermeable to Thorotrast, and it apparently maintains the integrity of the joint space during subsequent healing.

THIRD ANNUAL MURDOCK EQUEN MEMORIAL LECTURE

Ponce de Leon Infirmary announces the Third Annual "Murdock Equen Memorial Lecture" on Friday, May 31, 1968 at the Marriott Motor Hotel. Dr. Richard T. Farrior, President, The American Academy of Facial Plastic and Reconstructive Surgery, will present a paper entitled "Otolaryngologic Plastic Surgery." The lecture is open to all otolaryngologists; for further information contact Dr. Charles D. Smithdeal.

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THE MONTH IN WASHINGTON

The American Medical Association stated that the regional medical programs had showed good progress in the early stages but urged that Congress order an early evaluation by a non-government agency.

The AMA position was outlined by Bland W. Cannon, M.D., of Memphis, Tenn., a member of the Association Council on Medical Education, in testimony before the House Subcommittee on Public Health and Welfare. The subcommittee was considering Administration legislation to extend the regional medical program law for five years.

Subcommittee members reacted favorably to an AMA recommendation that the extension be for only three years. Some of the congressmen also indicated opposition to a recommendation by Michael DeBakey, M.D., of Houston, Tex., that appropriations for the regional medical programs be increased sharply.

"We view with favor the early progress of RMP, its ability to build on existing patterns of medical care (sometimes adding new features or changing old ones as local demands and resources make possible) and the local flexibility which allows the program to make a real contribution to the health care of our nation," Dr. Cannon said. "At the same time, we recognize that the concept of the Regional Medical Program is still in its very early stage of existence and that it is difficult to fully appraise the program. We do not know, for example, how much this program adds to the stress on an already overtaxed supply of available medical manpower.

"There is some concern that the proliferation of federal health programs substantially contributes to the rise in health care costs. For this reason, we are pleased that H.R. 15758 provides for an evaluation of the program. We would suggest, however, that the evaluation begin July 1, 1968, rather than July 1, 1969, since 'evaluation' should be an integral part of the planning. We also suggest that the subcommittee consider further amending Section 102 to provide that the evaluation shall be made by a non-government agency. . . .

"We recommend that the subcommittee delete the open-end authorization for funds for the four fiscal years ending after June 30, 1969. In view of the fact that we are still dealing with a relatively untried program, we believe it would be wise to limit the authorization to such sums as this subcommittee may determine to be reasonable, rather than to provide for 'such sums as may be necessary for the next four fiscal years.' "

Henry Brill, M.D., of Brentwood, N.Y., chairman of the AMA's Committee on Alcoholism and Drug Dependence, said that the AMA supported the part of the legislation authorizing federal grants for construction of facilities for a new program for alcoholic and narcotic addict rehabilitation.

"However," he said, "we have long felt that funds for staffing and operation are properly the responsibility of the community, once the major burden of construction has been met with federal assistance."

* * *

The American Medical Association and the Association of American Medical Colleges announced a joint

policy designed to increase the number of medical students.

The statement "emphasized the urgent and critical need for more physicians if national expectations for health services are to be realized," and listed immediate and long-range steps that should be taken.

Immediate steps:

1. Increase the enrollment of existing medical schools.

2. Foster curricular innovations and other changes in the educational programs which could shorten the time required for a medical education and minimize the costs.

3. Meet the need for innovation in educational programs and to encourage diversity in the character and objectives of medical schools. The development of schools of quality where a primary mission is the preparation of able physicians for clinical practice as economically and rapidly as possible is to be encouraged.

"A longer-range approach to the need for physicians is the development of new medical schools," the statement said. "This approach will not solve our immediate, urgent need for more physicians but it is essential for meeting the national needs of 1980 and beyond.

"To implement the measure enumerated above will require adequate financial support from governmental and various private sources for:

"1. Construction of facilities to expand enrollment of existing schools and to create new schools.

"2. Support of the operational costs of medical schools.

"3. Stimulation and incentive for educational innovation and improvement."

* * *

Wilbur J. Cohen, a key proponent of medicare, was named by President Johnson to succeed John W. Gardner as Secretary of Health, Education and Welfare.

Cohen, now 54, started with the federal government in the early thirties and helped draft the social security program. Recognized by Congress as an expert on social security, he was the leading architect of medicare and played a prominent role in getting Congressional approval of the program.

He had been undersecretary of HEW since June 1965. For the previous four years, he had been assistant secretary of HEW.

At a news conference following his appointment to the top HEW post, Cohen foresaw health care accounting for as much as 50 per cent of total welfare costs. He urged that voluntary private health insurance be improved. But he said that he did not believe private programs could be improved sufficiently to eliminate the need for government help in dealing with the health care needs of low income groups and the disabled.

"Medicare and medicaid have had some impact on higher medical costs," Cohen said. "But I think doctors' costs are going to taper off. Hospital costs are going to continue to rise but there is a problem of antiquated and inefficient methods. This can be changed."

Soon after Gardner's resignation became effective, Cohen announced major steps in the reorganization of HEW's health activities. Unified direction of HEW's major health agencies was assigned to Dr. Philip R. Lee, Assistant Secretary for Health and Scientific Affairs. Dr. William H. Stewart, Surgeon General of the

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MONTH IN WASHINGTON / Cont'd

Public Health Service, was named principal deputy to Dr. Lee.

Dr. Lee was given direct authority over the Public Health Service and the Food and Drug Administration. Dr. Stewart and Food and Drug Commissioner James L. Goddard, M.D., will report directly to the Assistant Secretary, while continuing to carry out their present administrative functions.

Dr. Lee's responsibility also was expanded to include overall health policy direction and coordination of other health programs, including medicare, medicaid and the health activities of the children's bureau.

In his 1968 message to Congress, President Johnson had directed the HEW secretary to submit "a modern plan of organization to achieve the most efficient and economical operation of the health programs of the federal government."

"In the past four years," Cohen said, "31 major new laws have been enacted that increase the Department's authority, responsibility and appropriations in the field of health.

"The total federal investment in health has grown from approximately $3 billion in 1960 to nearly $14 billion in 1968, and $16 billion proposed in 1969. Because of new programs, like medicare and medicaid, the HEW health investment alone has more than tripled in the past three years, from $2.6 billion in 1966 to $9.6 billion this fiscal year, and $10.9 billion proposed for 1969."

In a reassignment of agency responsibilities, the National Institutes of Health was expanded to include the present NIH, the Bureau of Health Manpower and the National Library of Medicine. The Health Services and Mental Health Administration were set up with responsibility for all other functions previously assigned to the Public Health Service. These two new agencies, along with the present Food and Drug Administration, now make up an expanded and more comprehensive Public Health Service.

Dr. James A. Shannon, Director of the National Institutes of Health, was named Director of the newly constituted NIH. Dr. Robert Q. Marston, Director of the Division of Regional Medical Programs, was named Acting Administrator of the Health Services and Mental Health Administration. Dr. Goddard continues as Commissioner of Food and Drugs. The heads of these three agencies will report directly to Dr. Lee under the new organizational setup.

From the Washington Office
American Medical Association
April 5, 1968

EXAMINATION DATE

State Board
of
Medical Examiners

June 11, 12, 1968

Mitchell-Pryor Building
166 Mitchell-Pryor St.
Atlanta, Georgia

1968 CALENDAR OF MEETINGS

National

May 19-22—National Tuberculosis Association, Rice Hotel, Houston, Texas.

May 19-23—American Thoracic Society, Rice Hotel, Houston, Texas.

May 20-24—The Prevention and Early Detection of Disease in Clinical Practice, ACP Postgraduate Course, University of Pennsylvania, Philadelphia, Pa.

May 22-24—Postgraduate Course in Pediatrics, Children's Hospital, Washington, D.C.

May 22-27—Refresher Course in Diagnostic Radiology, University of Cincinnati College of Medicine, Cincinnati, Ohio.

May 23-25—Pediatric Hematology and Malignant Diseases, University of Virginia School of Medicine, Charlottesville, Virginia.

May 24—Current Concepts in the Etiology and Treatment of Diabetes Mellitus, Georgetown University Hospital, Washington, D.C.

May 27-29—American Ophthalmological Society, Homestead, Hot Springs, Va.

June 6-8—Tenth Biennial Cardiovascular Seminar, Doral Country Club, Miami, Florida.

June 7-9—Society of Biological Psychiatry, Washington-Hilton Hotel, Washington, D.C.

June 13-16—American Association of Neuropathologists, Washington-Hilton Hotel, Washington, D.C.

June 13-17—American College of Chest Physicians, Hilton Hotel, San Francisco, Calif.

June 15-16—American Diabetes Association, Sheraton Plaza, San Francisco, Calif.

June 16-20—American Medical Association Annual Meeting, San Francisco, Calif.

June 16-20—American College of Preventive Medicine, San Francisco, Calif.

June 17-19—American Neurological Association, Washington-Hilton, Hotel, Washington, D.C.

June 17-21—Workshop in Electrocardiography, The Tides Bath Club, Redington Beach, Florida.

June 18-19—American Medical Women's Association, Waldorf Astoria Hotel, New York, N.Y.

June 30-July 3—International Congress of Primatology, Biltmore Hotel, Atlanta, Ga.

MILLION DOLLAR MENTAL HEALTH PROGRAM SLATED

A $1.6 million comprehensive community mental health project has been approved for Augusta. To be financed by $821,104 in U. S. Public Health Service funds and an equal amount in local matching funds, this project will bring across-the-board mental health care to patients from six counties: Richmond (Augusta), Lincoln, Wilkes, Burke, McDuffie and Columbia.

The program will be jointly operated by Talmadge Memorial Hospital, the University Hospital and the Richmond County Health Department. Services in the six county area will be coordinated by Richmond County Health Department which is under the direction of Dr. Abe Davis.

Dr. Ilhan Ermutlu, director of the Division's Community Services Branch, worked with local health officials in the Augusta area in preparing the application for federal funds. According to Dr. Ermutlu, "The new comprehensive program will work closely with the state owned Augusta Regional Hospital which is now over half completed."

This will be the sixth such comprehensive program for Georgia. Earlier projects, funded and in various phases of construction, are underway in Athens, Macon, Clayton County, Thomasville and Valdosta.

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HIGHLIGHTS OF COUNCIL MEETING, MARCH 16-17, 1968–ATLANTA

This summary is being published so that the MAG membership may be advised in brief of the actions of the Association's Council and Executive Committee. It covers only major actions and is not intended as a detailed report. Full minutes of these meetings are available upon any member's request to the MAG Headquarters Office.

Attorney General Arthur Bolton's Ruling Regarding Osteopathic Prescription Privileges was thoroughly reviewed for the Council by Mr. William B. Spann of Alston, Miller & Gaines, with the result that Council authorized Mr. Spann to enter into litigation to resolve the matter, after meeting with the Attorney General and determining the best procedure.

Third Party Payments and the Emory-Grady Agreement were discussed by Attorney John Moore who emphasized that progress had been made in his negotiations with Mr. Trammell Vickery, Legal Counsel to Grady Memorial Hospital. Mr. Moore was authorized to continue those negotiations in such a way as to protect the individual's voice in the distribution of the funds, and that the negotiations be in compliance with MAG-AMA policy.

Liaison Meetings With Board of Medical Examiners regarding Osteopathic Practice Privileges continue with the Osteopaths most anxious to keep the avenue open for further discussions. Council requested President Mauldin to continue those talks.

The Ad Hoc Committee on Employment of a Physician to work full time presented its report. The Committee's recommendation is that while it is not feasible to pursue the matter at present, further evaluation should be made at a later date.

Annual Session Committee Chairman, Dr. Luther Vinton, informed the Council of the recommendation in his annual report, that commercial exhibits be eliminated after the 1968 meeting, and he received the backing of the Council.

Headquarters Expansion Committee Chairman, Dr. J. G. McDaniel, reported on the alternative proposals received from the architects and made a recommendation that Council give its approval to expanding the building with the addition of up to 10,000 square feet at the second story level and improving the parking lot capacity. Council voted to have the Committee proceed with this plan and at the same time seek the cost of test borings for data on foundations which would support up to six stories. The Council then requested the Committee to also investigate the feasibility of a high rise building of approximately twenty-five stories.

Other Actions Included the Following:

—Approved the 1967 Audit.

—Reviewed and approved the Annual Report of the Constitution & Bylaws Committee which contained several proposed changes.

—Heard a report from the Chairman of the State Board of Health, Dr. P. K. Dixon, which called on MAG to establish a position in expectation of that day when appropriated funds for Title XIX are depleted.

—Received a report from the Woman's Auxiliary President, Mrs. James Manning, in which she asked MAG's help in increasing the Auxiliary membership, and providing space in any proposed Headquarters Expansion Plan for an Auxiliary office.

—Noted appointment of Dr. Louie H. Griffin to the State Board of Health to succeed Dr. J. K. Quattlebaum who resigned. Dr. Griffin's term will run until July 1, 1969.

—Heard a report that the Insurance and Economics Committee is continuing its negotiations with the Liability Insurance Carrier over the Company's request for an 11% increase in premium, and a broadening of the categories of premium structure.

—Voted to invite the Presidents of the two Georgia Student AMA Chapters to attend the May Council and House of Delegates sessions as the guests of MAG, and that they be recognized in the House.

—Made note of the projected 10% increase in Journal MAG postage rates.

—Heard a report that no local claims review chairman had been requested to review any claims by the Medicare Carrier.

—Received the information from the AMA that Dr. J. Frank Walker of Atlanta had been appointed to their Committee on Health Manpower, and Dr. Carter Smith of Atlanta to their Committee to Study the Modus Operandi of the Scientific Sections.

—Set the next meeting for 2:00 p.m., Saturday, May 4, 1968, Teakwood Room, Augusta Town House.

NEW PAMPHLET WARNS OF DANGERS FROM HEALTH CULTISTS AND QUACKS

The old-fashioned spieler selling magical cures for all ills has practically disappeared from the American scene. But more modern pitchmen are still bilking the public out of more than $2 billion a year for questionable treatments. Even more serious is the consequent loss of precious time before reliable medical care is sought.

The victims of odd-ball diets, off-beat treatments, or, at best, useless pills, capsules, and liquids come from every educational and economic level. The pseudo-scientific quacks and health cultists to whom millions fall prey are exposed in *Fads, Myths, Quacks—and Your Health*, a new Public Affairs Pamphlet by Jacqueline Seaver. The pamphlet is available for 25 cents from the Public Affairs Committee, 381 Park Avenue South, New York, N.Y. 10016.

THE TAR BANDAGE

By C. B. LEITNER, M.D., Columbus

I wish to call the attention of the medical profession to a new and efficacious, to me at least, dressing for wounds, namely: the tar bandage. The advantages that I claim for this dressing are, its perfect protection against the deposit of the fly; the stability with which it retains its position; and, if the theory be true, as a preventive and a destroyer of parasitic organisms. I am satisfied now, had this treatment been adopted during our late civil war, hundreds of lives would have been saved by it, if from no other cause, certainly from its protective powers against inoculation from erysipelas, gangrene, etc., for this bandage acts as a perfect shield to the wound.

I could record six or eight cases treated by this process, but will report only one, a very difficult and obstinate case, of a negro man, thirty-five years of age, deaf and dumb. On the 27th of July, 1875, this negro was run over by the cars. His tibia and fibula, six inches below the knee, were crushed, the soft parts converted into a fibrous mass, leaving, however, enough of the gastrocnemius muscle to form a flap. Assisted by Dr. Wynne, I amputated the leg two inches below the lower insertion of the tendon of the patella. The flaps were drawn and two or three sutures taken, then tarred strips of cloth were applied, as adhesive strips would have been used, for six to eight inches above the wound. The roller bandage was then placed over these, and the whole well tarred.

I wish to call attention to another advantage connected with this dressing—that is, it does not require re-adjusting so often as other modes, only every twelve or fourteen days, unless some constitutional disturbance should be apparent.

The leg was not dressed again until the 6th of August, notwithstanding the weather was the warmest I ever experienced in Georgia, and the subject perhaps one of the worst that ever happened to such an accident. His bowels were loaded with unripe fruit, and with every kind of foreign matter that a tramp, at that season of the year, could procure, besides, he had upon his head, arm and shoulder two or three badly contused wounds, which were treated by the application of tar ointment. The leg was not dressed the third time until the 2d of September, when he was turned over to the nurse, and in a week he was out upon crutches.

In applying for the first time the bandage, at the most dependent part a little V-shaped valve was cut, to allow the escape of pus. He was not annoyed by a fly, or by any bad symptoms, and the recovery was very speedy, which I attributed to non-interference with the bandage. I am perfectly satisfied in my own mind that the frequent dressing of wounds is a source of great irritation, to say nothing of the amount of granulations that are broken up. Should there be any mischief going on under the bandage, the constitutional effects must be apparent.

I have had five or six other cases, though not of so serious a character, in which the bandage was never removed until the wound was entirely well. I will report, however, a case of a negro woman, Elvira, aged 60 years, upon whose hand fell a large window sash, laying open the index finger its entire length, to which the tar bandage was applied, and not removed until a perfect recovery had taken place. In four other cases the wounds were made by sharp instruments, in which the same treatment, without the sutures, was used, and the result, in every case, was identical.

My manner in preparing this fresh pine-tar ointment, is to put the tar into a glass vessel, and place the vessel into a pot containing water; after the water has boiled for a half hour, the vessel containing the tar is set aside until all the foreign matter is precipitated, then decant, leaving the foreign matter at the bottom; finally, add one part of sweet oil to twenty parts of the tar. After the roller bandage is adjusted, in amputations, this ointment should be thoroughly applied, once in four or five days being sufficient. In wounds, cloth strips can be used as one would use adhesive strips. I would recommend cold water dressings to the wound.

I hope my professional brethren will give this a trial, and meet with the same success that has attended my efforts.

From Transactions of the Medical Association of Georgia, Twenty-ninth Annual Session, Atlanta, April 17-19, 1878.

GEORGIA HIGHWAY SLAUGHTER

Yearly Totals

1968 to date	384 Killed
1967	1,615 Killed
1966	1,605 Killed
1965	1,354 Killed
1964	1,314 Killed
1963	1,278 Killed
1962	1,106 Killed
1961	1,017 Killed

Through March, 1968
384 KILLED

Same Period 1967
370 KILLED

March, 1968
130 KILLED

Economic Loss

1968 to date	$ 72,960,000
1967	306,860,000
1966	288,900,000
1965	243,720,000
1964	236,520,000
1963	230,040,000
1962	199,080,000
1961	162,720,000

THE REGIONAL MEDICAL PROGRAM PICTURE: STATE AND NATIONAL

Some one hundred Georgia physicians and hospital and medical center administrators attended the semi-annual meeting of the Georgia Regional Medical Program's Local Advisory Group Chairmen on March 24 at the Hilton Inn in Atlanta.

Roland Peterson, Planning Branch Chief of the Division of Regional Medical Programs in Washington told the representatives that: "One of the most significant developments in the advancement of Regional Medical Programs—and one in which Georgia in a very real sense led the way—has been the creation of local, community oriented advisory groups to plan activities designed to meet the needs of their particular local areas and to strengthen relationships between local institutions and the medical centers."

He went on to say that: "Georgia can also take just pride in the fact that its State Medical Association, Public Health Department and two medical schools have taken the initiative in leading the Program's development. It is one of only five regions in which the medical association is serving as the coordinating headquarters—or grantee—for its program."

Reporting on progress at the national level, Mr. Peterson said that more than 1,200 organizations are participating in the development of Regional Medical Programs. These include all of the nation's medical schools, many state and local medical societies, state hospital associations, and numerous official and voluntary health agencies, with hospitals making up the largest single group of participating institutions. Of the nearly 2,000 individuals serving on regional advisory groups throughout the country, practicing physicians comprise 22 per cent, other health professionals 8 per cent, medical center officials 16 per cent, hospital administrators 13 per cent, voluntary and official health agency representatives 12 per cent and 7 per cent respectively, and interested and informed members of the public 15 per cent—businessmen, labor officials, lawyers, and other community leaders. (Composition of GRMP's Regional Advisory Group shows similar representation percentagewise.)

Planning grants have now been made to fifty-three regions; 12 have begun operational activities and another 12, including Georgia, have operational grant applications under review. Funds awarded to date for planning grants total over $33 million; and approximately $11.9 million has been awarded for operational grants.

Mr. Peterson also related some of the trends and developments that may be in the offing.

1) Monies are, and will be, available through fiscal year 1969 for continued and hopefully increased funding of Georgia's and other regional programs.

2) The request for legislative extension of the program (Public Law 89-239) for a period of five years (through June 30, 1973) has been introduced in both the House and the Senate.

3) One per cent of Regional Medical Program appropriations is to be set aside for evaluation (directly or by grants or contracts) of the program.

4) Authority has been requested by the Division of Regional Medical Programs to make grants to any public or non-profit private agency or institution for services needed by, or which will be of substantial use to, any two or more regional medical programs.

5) Authority has also been requested to make grants to combinations of, as well as single, public or non-profit private agencies and institutions to facilitate funding of interregional activities.

6) Expansion of the National Advisory Council from 12 to 16 members has been recommended.

7) Inclusion in the Program of Guam, American Samoa, and the Trust Territories of the Pacific has been proposed.

8) Permission has been requested for dentists as well as physicians to make referrals under the Program and for VA and other Federal hospitals to participate in and receive funds through Regional Programs.

No provision has been made for new construction authority, due partially to budget constraints and the fact that a National Advisory Commission on Health Facilities, headed by Georgia's Boisfeuillet Jones, was recently appointed to look into and make recommendations with respect to the whole area of Federal Assistance for Health Facilities Construction.

Mr. Peterson closed by saying that continued and indeed rapid expansion and growth of Regional Medical Programs seems assured.

Dr. J. Gordon Barrow, Georgia Regional Medical Program Director, in his review and summary of the Georgia Program, said "Our local advisory groups, centered in community hospitals across the State, have served to stimulate a new interest in continuing education and research, in recognizing community health problems, and in measuring the effectiveness of current approaches to disease problems. This concept of local initiative, fundamental to the Regional Medical Programs from the beginning, requires each area to develop its own approach suited to its needs and resources and to affiliate local direction with the overall program of health planning and operation of the Georgia Regional Medical Program."

"Continuation Planning Grant funds in the amount of $341,824 and a Supplemental Grant allocation of $213,255 have been awarded to GRMP by the National Institutes of Health for the period from January 1, 1968, to December 31, 1968, to finance the staff expansion necessary to continue planning and to prepare for and develop operational activities. The operational grant request submitted March 1 has a budget of slightly less than $2 million. If approved, it is anticipated that operational projects in the areas of continuing education and training, related demonstrations of patient care, and research in the delivery of health care services will get under way in Georgia about July 1."

In addition to Dr. Barrow, other participants on the one-day program were: Victor A. Moore, M.D., Director of Medical Education, University Hospital, Augusta; J. W. Chambers, M.D., GRMP Program Coordinator; Robert R. Smith, M.D., GRMP Associate Director; and the Chairmen of the GRMP Task Forces.

HIGHLIGHTS OF THE MAG EXECUTIVE COMMITTEE OF COUNCIL MEETING, APRIL 7, 1968–ATLANTA

This summary is being published so that the MAG membership may be advised in brief of the actions of the Association's Council and Executive Committee. It covers only major actions and is not intended as a detailed report. Full minutes of these meetings are available upon any member's request to the MAG Headquarters Office.

Progress Report on Attorney General's Ruling Re Osteopathic Prescription Privileges (Mr. William B. Spann, Attorney). The March Council authorized the MAG Attorney through his partner, Mr. William B. Spann, Jr., to negotiate with Attorney General Arthur Bolton in the hope of having him reconsider his February 13 ruling with regard to prescription drugs, and to proceed with litigation if necessary. A delegation of attorneys including Mr. Spann, Mr. Francis Shackleford and Mr. Dean Copeland called on Mr. Bolton March 26 and in a most pleasant meeting received his agreement to review his opinion in light of a memorandum setting forth the position of MAG. The Executive Committee will hear further regarding this meeting and the prospects for a change of the opinion.

Action: Mr. Spann reported on a second conference with Mr. Bolton which leads them to believe he will reconsider his ruling.

★ ★ ★

With regard to the claims received by MAG from osteopaths for work done on qualified claimants of the Military Medicine (CHAMPUS) program, the attorneys will report on their study of the claims and advice that they be rejected on the basis of our position on their restricted practice privileges, and the expectation that a suit might result from one of these claims, which could work to our advantage in testing the Attorney General's ruling.

Action: It was reported that the Denver Office of CHAMPUS had requested that osteopathic claims be returned to them for payment. Mr. Spann advised MAG to comply with that request. The Executive Committee also determined that a cover letter should be forwarded with each osteopathic claim expressing our opinion that osteopaths should be paid only for the manipulative practice allowed under Georgia law.

★ ★ ★

Since January 1, 1967, podiatrists have been billing directly to the CHAMPUS office in Denver. In a recent letter from the Contracting Officer, MAG was asked to consider the feasibility of paying the podiatry claims for CHAMPUS. The Executive Committee is to consider this request.

Action: It was determined that the payment of podiatry claims was more clearly justifiable in the Georgia law than were osteopathic claims. A motion was adopted that podiatry claims should be paid subject to the usual claims review procedure.

MAG Position on Title XIX Funds Depletion (John T. Mauldin, M.D.). The March 1968 Council meeting heard a report by Dr. P. K. Dixon, Chairman of the State Board of Health, named carrier for Title XIX in Georgia, in which he predicted the total depletion of appropriated funds in Georgia for payment to physicians for treatment of Medicaid patients. Dr. Dixon called on MAG to consider this prospect and establish what its position will be on the matter should it happen.

Action: This matter was referred to MAG's Title XIX Committee for study and report to the September meeting of the Executive Committee.

★ ★ ★

The Georgia Chapter, Arthritis Foundation (J. Rhodes Haverty, M.D.), will sponsor a statewide Governor's Conference on the Prevention of Disability from Arthritis on September 21 and 22, 1968. Similar conferences have been held in Arizona, California and Pennsylvania and others are now in the planning stage. The budget for the conference has been set at $4,700.00, of which $2,500.00 is expected from the U. S. Public Health Service on a purchase order for a printed report of the conference. MAG member Dr. Daniel D. Hankey is this year's President of the Georgia Chapter, and he is requesting that MAG contribute $500.00 to help offset the balance of the budget in excess of the federal funds. Approximately a dozen organizations including the State Department of Public Health have been asked to contribute and most will respond with help to defray the expenses of particular speakers. The greatest need is for unrestricted funds.

Action: Following a discussion of precedent, a motion was adopted instructing the Secretary to write to Dr. Hankey that it is not the Association's policy to contribute to organizations.

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Progress on Hart County Hospital Investigation (Charles T. Cowart, M.D., Chairman). The Resolution from the Elbert-Franklin-Hart County Medical Society requesting MAG to investigate the dispute at Hart County Hospital between the Medical Staff and the County Board of Finance (Commissioners), the legal governing authority of the Hospital, was referred by the March Council to the MAG Hospital Activities Committee. Committee Chairman Dr. Cowart will provide the Executive Committee with a progress report on his investigation.

Action: The matter was referred to Dr. Mauldin for further action.

★ ★ ★

Progress Report of Headquarters Expansion Committee (J. G. McDaniel, M.D., Chairman). On March 21 President Mauldin signed the contracts authorizing the architectural firm of Thompson and Hancock to proceed with the drafting of preliminary plans for an

addition of up to 10,000 square feet to our existing building. At the same time the Headquarters Expansion Committee has been investigating the many facets of building management in the event the association may wish to add additional space for rental purposes later. The Executive Committee will be given a complete report by Chairman McDaniel.

Action: Dr. McDaniel was authorized to negotiate with the architects in those steps necessary to complete the preliminary drawings for a 10,000 square foot addition. This would include test borings and soil samples, with a mail poll of the Council if necessary for appropriating up to $1,500 for these steps.

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AMA Socio-Economics of Health Care Congress, March 22-23, Chicago (John T. Mauldin, M.D.). Dr. John T. Mauldin, Dr. Neal Yeomans, and Mr. Edwin Smith were in attendance at the second Annual Congress on Socio-Economics sponsored by the AMA Division on Medical Service now headed by AMA Past President Dr. Charles Hudson. Dr. Mauldin will comment on the long program which included presentations on many controversal methods of delivery of patient care.

Action: Dr. Mauldin and Mr. Smith described several of the presentations in detail and conveyed the message of the meeting in general.

★ ★ ★

Research Project Contract With Public Health Service (J. Gordon Barrow, M.D.). The Executive Committee on January 7 heard a request by Dr. Barrow that a project of independent research done by him in conjunction with a North Carolina physician be underwritten by MAG up to $2,500, based on a purchase order from the U. S. Public Health Service. The committee approved the use of MAG as a responsible corporate entity to receive the government funds and transfer them to Dr. Barrow for his use. Additional contract provisions were added to the project which would include the hiring of an MAG employee to work at the Research Triangle Institute in Durham, N. C., and increase the scope of the project to $10,000. Council, at its March meeting, rescinded the previous action of the Executive Committee and referred the matter back for additional clarification. Dr. Barrow will explain the expansion of the project to date.

Action: On being assured that all work involved would be handled on a consultant basis and that no money would be spent until the grant was received, the Committee approved the use of MAG as the transfer agent for this project. In a subsequent action the Committee approved the practice of Dr. Barrow's reading E. K. G.'s at Ga. Baptist Hospital on his own time.

Appointment of Mr. Wilbur J. Cohen as Secretary of HEW (Dr. Mauldin). By a telegram dated March 28, 1968, we were advised that on March 26, 1968, the California Medical Association's House of Delegates passed a resolution urging all State Medical Associations to help block Mr. Cohen's confirmation in the U. S. Senate. The American Association of Physicians and Surgeons, through Bulletin 3-68 has already begun a publicity campaign against Mr. Cohen's confirmation.

Action: This matter was received for information.

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Appointments (J. Rhodes Haverty, M.D.). The Comprehensive Health Planning Council offered MAG the opportunity to submit three nominations in February for appointment to the Task Force on Physician Manpower. President Mauldin submitted the names of William Moore, M.D., Atlanta; H. Harper Butterworth, M.D., Decatur; and Joseph S. Wilson, M.D., Atlanta. At the first organizational meeting of the Task Force, Dr. Moore was elected Chairman.

Action: Received for information and confirmed the appointments.

★ ★ ★

Recent elections at the March 1 meeting of the Board of the Atlanta Blue Shield Plan resulted in Dr. Edwin C. Evans being named President. Other officers will be announced at the Executive Committee meeting.

Action: Received for information.

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At a regular meeting of the MAG Council September 28-29, 1963, Dr. J. G. McDaniel, Dr. Virgil B. Williams and Mr. Milton D. Krueger were named as the Administrative Committee for the employees pension plan. Mr. Robert T. Russell, Trust Officer for Fulton National Bank, has provided the necessary forms and requests the naming of a new Committee.

Action: The Executive Committee elected Dr. J. G. McDaniel, Dr. John Atwater, and Mr. Edwin F. Smith to the Administrative Committee.

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A presentation by Dr. John T. Godwin in which he explained the progress of development of the Health Careers Council of Georgia.

Action: The Executive Committee then elected Dr. Godwin as voting representative to the H. C. C. of Ga. and Dr. Lamar Peacock as alternate representative. By official action the Executive Committee also voted to apply for agency membership in the H. C. C. of Ga.

★ ★ ★

Date and Site of May Meeting: May 4, 1968, 10:00 a.m., Fenwick Room, Augusta Town House.

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OBSTINATE CASE OF HICCOUGH

By J. B. ROBERTS, M.D., Sandersville

On the 15th of October, 1876, I was sent for to visit Miss T., aged about sixteen years, living in the country, seven miles from my office. I found her suffering with hiccough. Her mother stated to me that she had been suffering about three days, and seemed to be completely exhausted. I learned that she had had two or three previous attacks, was treated by Dr. H., and after trying various remedies prescribed by him, and all the remedies that could be suggested by her neighbors, without any relief, she had sent for me. I gave her two large doses of morphine which had a very happy effect. She married a short time after this, became pregnant, and got along well until October, 1877, when she was delivered of a fine boy. A few days afterwards, October 30th, I was sent for again, and when I arrived, found her in about the same condition as in October, 1876, so I prescribed large doses of morphine with the same happy results. March 21st, 1878, I was sent for again (she now lives about nine miles from my office) to visit her as soon as possible. I arrived at her bed side about ten o'clock at night and found her resting very quietly. She stated that she had suffered a great deal for two days, but had taken the medicine I left for her very freely, and at last had obtained relief. The next day the hiccough commenced again and continued at intervals for several days, until April 4th, I was sent for again in great haste, and when I arrived, found her in a worse condition than I had ever seen her. She was quite feeble, had very little use of herself, her throat was very sore, but did not seem to be swollen, and the noise she made at each respiration could be heard about one hundred yards from the house. Morphine, bromide of potassium, hydrate of choral, and several other remedies, all failed to give relief at this time, and I thought my patient would die from exhaustion, so I decided to remain with her as long as I could and administer chloroform. This seemed to relieve her as long as she remained under its influence, but so soon as the effects of the chloroform passed off, the hiccough would commence again. I had to persevere in this treatment about three days before the hiccough ceased entirely.

Now, if some medical gentleman will suggest a remedy to prevent these attacks, I shall certainly feel very grateful.

From Transactions of the Medical Association of Georgia, Twenty-ninth Annual Session, Atlanta, April 17-19, 1878.

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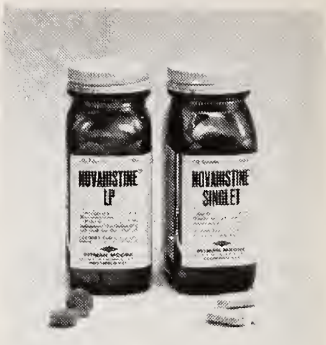

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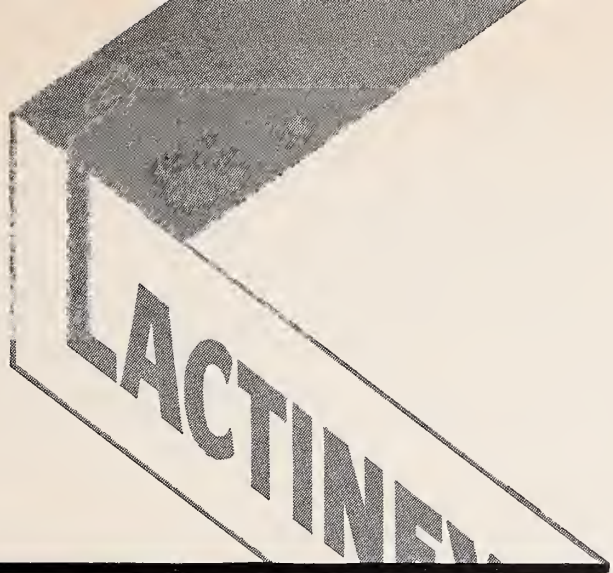

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(1) Siver, R. H.: CMD, *21*:109, September 1954. (2) Frykman, H. H.: Minn. Med., *38*:19-27, January 1955. (3) McGivney, J.: Tex. State Jour. Med., *51*:16-18, January 1955. (4) Quehl, T. M.: Jour. of Florida Acad. Gen. Prac., *15*:15-16, October 1965. (5) Weekes, D. J.: N.Y. State Jour. Med., *58*:2672-2673, August 1958. (6) Weekes, D. J.: EENT Digest, *25*:47-59, December 1963. (7) Abbott, P. L.: Jour. Oral Surg., Anes., & Hosp. Dental Serv., 310-312, July 1961. (8) Rapoport, L. and Levine, W. I.: Oral Surg., Oral Med. & Oral Path., *20*:591-593, November 1965.

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JOURNAL OF THE MEDICAL ASSOCIATION Georgia

First Session, House of Delegates

Monday, May 6, 1968

THE FIRST SESSION of the House of Delegates of the Medical Association of Georgia was called to order by Speaker J. Frank Walker, Atlanta, at 9:45 a.m., in the Embassy Room, Augusta Town House Motor Inn, Augusta, Georgia, in conjunction with the 114th Annual Session of the Medical Association of Georgia.

Speaker Walker called for a report of the delegates' attendance. Dr. H. Hilt Hammett, LaGrange, Chairman of the House of Delegates Credentials Committee, reported that there were 119 delegates present and registered, representing 50 component societies, and that there was a quorum of over 40 members present and accounted for. A complete report made by the Credentials Committee on the attendance at the First Session of the House of Delegates follows:

Attendance

In a compilation of attendance taken from the official roll, 50 county medical societies were represented by their duly elected delegates or alternates. Twenty-four county medical societies were not represented at this First Session. Of a total of 162 authorized delegates from their respective medical societies, the official roll showed 119 delegates present at this First Session.

BALDWIN: A. C. Martinez; BARTOW: W. B. Quillian, Jr.; BEN HILL-IRWIN: H. L. Dismuke; BIBB: Charles G. Burton, Milton I. Johnson, J. G. Etheridge, Charles A. Lanford; BURKE: E. R. Hensley; CARROLL-DOUGLAS-HARALSON: J. Harvey Beall, Phil C. Astin; GEORGIA MEDICAL SOCIETY: Lee Howard, Jr., Irving Victor, John L. Elliott, Joseph A. Mulherin; CHATTAHOOCHEE: Rupert H. Bramblett; CHEROKEE-PICKENS: C. J. Roper; CRAWFORD W. LONG: M. A. Hubert; CLAYTON-FAYETTE: Wells Riley; COBB: James H. Manning, Donald R. Rooney, Remer Y. Clark; DECATUR-SEMINOLE: Henry A. Bridges; DEKALB: W. Frank Matthews, David L. Morgan, Stanley P. Aldridge, M. Hobson Rice, Luther M. Vinton, Ellis B. Keener; DOUGHERTY: W. P. Rhyne, Lawrence T. Crimmins; CAMDEN-CHARLTON: R. R. McCollum; EMANUEL: R. J. Moye; FLINT: J. T. Christmas; FLOYD: W. Henry Lucus, A. Richard Gray, James H. Smith; ELBERT-FRANKLIN-HART: John B. O'Neal; FULTON: J. Watts Lipscomb, John N. McClure, F. W. Dowda, Paul A. Lavietes, J. G. McDaniel, J. K. Schellack, Joseph L. Girardeau, J. Rhodes Haverty, W. Perrin Nicolson, III, J. Frank Walker, Linton H. Bishop, Edgar Woody, Jr., Robert E. Wells, John A. Jarrell, Jr., Fleming L. Jolley, Joseph S. Wilson, James Kaufmann, John S. Atwater, Edwin C. Evans, L. Newton Turk, III, G. Lester Forbes, Irving L. Greenberg, Edwin C. Pound, Jr., Harrison L. Rogers, Jr., Charles E. Todd, Tully T. Blalock, Albert A. Rayle, Jr., Spencer S. Brewer, Jr., Don F. Cathcart, William L. McDougal, Jr.; GLYNN: C. S. Britt; HABERSHAM: Thomas N. Lumsden; HALL: Robert Anderson, B. S. Hardman, C. W. Whitworth; PEACH BELT: H. E. Weems, Virgil W. McEver; JACKSON-BANKS: E. W. Holloway; MCDUFFIE: Ernest L. Cook; MERIWETHER-HARRIS: J. Emmett Collins; MUSCOGEE: G. Bertling Smith, Henry H. Boyter, Luther J. Smith, II, Jack A. Raines, Jack Hirsch; OCONEE VALLEY: C. H. Dickens; OCMULGEE: W. E. Coleman; POLK: Don Schmidt; RICHMOND: Preston D. Ellington, William A. Fuller, Ronald Galloway, George E. VanGiesen, Daniel B. Sullivan, Henry D. Scoggins, Menard Ihnen, Stuart H. Prather, Jr., Cecil A. White, Jr., Julius T. Johnson; SCREVEN: Katrine R. Hawkins; SOUTH GEORGIA: Fred C. Smith, Mack V. Greer; SOUTHEAST GEORGIA: George P. Sassos; SPALDING: Alex P. Jones, James Skinner; STEPHENS: Irving Hellenga; SUMTER: E. W. Waldemayer; THOMAS-BROOKS: Robert T. Cain, Donald J. McKenzie; TIFT: James F. Kirkpatrick; TRI-COUNTY: Frank T. Robbins; TROUP: Charles T. Cowart, H. Hilt Hammett; UPSON: T. A. Sappington; WALKER-CATOOSA-DADE: Fred H. Simonton, T. A. Cochran; WARE: F. E. Davis, L. C. Durrence; WAYNE: O. O. McGahee; WHITFIELD: E. T. McGhee, M. B. Lumpkin; WILKES: M. C. Adair; WORTH: H. G. Davis, Jr.

Credentials and Tellers Committee

Speaker Walker announced the prior appointments of the House of Delegates Credentials Committee and the appointments of the Tellers Committee as follows:

Henry Jennings of Gainesville registers with Miss Thelma Franklin, MAG Business Manager, and Miss Nancy Minor, MAG Secretary.

CREDENTIALS COMMITTEE: H. Hilt Hammett, LaGrange, Chairman; F. W. Dowda, Atlanta; B. S. Hardman, Gainesville.

TELLERS COMMITTEE: M. Hobson Rice, Decatur, Chairman; Jack A. Raines, Columbus; Irving Victor, Savannah.

Reference Committees

Speaker Walker appointed the following House of Delegates Reference Committees:

REFERENCE COMMITTEE NO. 1: J. Harvey Beall, Carrollton, Chairman; Stuart H. Prather, Jr., Augusta, Vice Chairman; Robert E. Wells, Atlanta; Charles B. Thomas, Newnan; Dan Sullivan, Augusta; and Wells Riley, Jonesboro.

REFERENCE COMMITTEE NO. 2: Alex P. Jones, Griffin, Chairman; James H. Smith, Rome, Vice Chairman; Joseph A. Mulherin, Savannah; Robert L. Brown, Atlanta; Jack McGee, Columbus; and R. J. Moye, Swainsboro.

REFERENCE COMMITTEE NO. 3: Edwin C. Evans, Atlanta, Chairman; H. G. Davis, Jr., Sylvester, Vice Chairman; A. C. Martinez, Milledgeville; M. A. Hubert, Athens; Walter L. Shepeard, Augusta; and Rupert H. Bramblett, Cumming.

REFERENCE COMMITTEE NO. 4: J. Watts Lipscomb, Forest Park, Chairman; M. B. Lumpkin, Dalton, Vice Chairman; Fred C. Smith, Valdosta; John H. Robinson, Americus; J. Randall Winburn, Jr., Savannah; and Fred H. Simonton, Chickamauga.

REFERENCE COMMITTEE NO. 5: Cecil A. White, Jr., Augusta, Chairman; Don Schmidt, Cedartown, Vice Chairman; James H. Manning, Marietta; Irving Hellenga, Toccoa; Albert A. Rayle, Jr., Atlanta; and John B. O'Neal, Elberton.

Approval of 1967 Minutes

To expedite the reading and adoption of the minutes of the 1967 Sessions of the House of Delegates held in conjunction with the 113th Annual Session of the Medical Association of Georgia convened on May 1-2, 1967, at the Marriott Motor Hotel, in Atlanta, Georgia, the Chair entertained a motion that the minutes as published in the June 1967 issue of the *Journal of the Medical Association of Georgia* be approved. On motion duly made and seconded, it was voted that these minutes be so approved as published in their entirety in the June 1967 issue of the *JMAG*.

Distinguished Guests

Speaker Walker then introduced fraternal delegates from neighboring states. Representing the State of North Carolina and its President, Robert Ross, was Dr. Amos Johnson, of Garland, North Carolina. Representing the State of Florida and its President, Dean Steward, was Dr. James T. Cook, Jr. Speaker Walker then recognized the two presidents of Student American Medical Association chapters in Georgia. The first was Mr. Christian Ramsey, President of the Student American Medical Association Chapter at Emory University and National Vice President of the Student AMA. Introduced next was Mr. Lucien Cousins, President of the Student American Medical Association Chapter at the Medical College of Georgia, Augusta.

Annual Reports

Speaker Walker called for the Annual Reports of Officers, Council, Councilors and Vice Councilors, Association Committees and other reports as introduced at this Session, which are listed below with the Reference Committees to which they were referred. The full report; the action by the Reference Committee; and the House of Delegates action is listed under the proceedings of the Second Session of the House of Delegates. (See pages 253 to 309.)

OFFICERS

President—Reference Committee No. 1
President-Elect—Reference Committee No. 3
Immediate Past President—Reference Committee No. 1
First Vice President—Reference Committee No. 3
Second Vice President—Reference Committee No. 4
Secretary—Reference Committee No. 5
Treasurer—Reference Committee No. 1
Speaker of the House of Delegates—Reference Committee No. 2
AMA Delegates—Reference Committee No. 2
AMA Alternate Delegate—Reference Committee No. 1

COUNCIL

Council of MAG—Reference Committee No. 4

COUNCILORS AND VICE COUNCILORS

First District Councilor—Reference Committee No. 3
Second District Councilor—Reference Committee No. 2
Third District Councilor—Reference Committee No. 1
Sixth District Councilor—Reference Committee No. 4

Seventh District Councilor—Reference Committee No. 1
Eighth District Councilor—Reference Committee No. 4
Ninth District Councilor—Reference Committee No. 5
Ninth District Vice Councilor—Reference Committee No. 2
Tenth District Councilor—Reference Committee No. 1
Bibb County Councilor—Reference Committee No. 1
Cobb County Councilor—Reference Committee No. 5
DeKalb County Councilor and Vice Councilor—Reference Committee No. 1
Fulton County Medical Society Councilors—Reference Committee No. 4
Georgia Medical Society Councilor—Reference Committee No. 1
Muscogee County Medical Society Councilor—Reference Committee No. 1
Richmond County Councilor—Reference Committee No. 2

ASSOCIATION COMMITTEES

Annual Session Committee—Reference Committee No. 5
Constitution and Bylaws Committee—Reference Committee No. 2
Finance Committee—Reference Committee No. 3
Professional Conduct Committee—Reference Committee No. 3
Traffic Safety Committee—Reference Committee No. 4
Woman's Auxiliary Advisory Committee—Reference Committee No. 5
AMA-ERF Committee—Reference Committee No. 4
Disaster Medical Care Committee—Reference Committee No. 4
Hospital Activities Committee—Reference Committee No. 4
Legislative Committee—Reference Committee No. 2
Maternal and Infant Welfare Committee—Reference Committee No. 5
Medical Education Committee—Reference Committee No. 4
Medical Ethics Committee—Reference Committee No. 3
Medical Review and Negotiating Committee—Reference Committee No. 3
Medicine and Religion Committee—Reference Committee No. 4
Mental Health Committee—Reference Committee No. 4
Nursing Liaison Committee—Reference Committee No. 5
Occupational Health Committee—Reference Committee No. 2
Paramedical Study Committee—Reference Committee No. 3
Public Service Committee—Reference Committee No. 4
Rural Health Committee—Reference Committee No. 4
School Child Health Committee—Reference Committee No. 2
Separate Billing Committee—Reference Committee No. 2
Special Activities Committee—Reference Committee No. 2
Ad Hoc Committee on Charting—Reference Committee No. 5
Ad Hoc Committee on Special Finance—Reference Committee No. 3
Headquarters Expansion Study Committee—Reference Committee No. 3

OTHER REPORTS

Report of the *Journal*—Reference Committee No. 1
Georgia Regional Medical Program—Reference Committee No. 1
Woman's Auxiliary—Reference Committee No. 3

Special Reports

Speaker Walker then recognized certain members of the Medical Association of Georgia for the purpose of giving Special Reports to the House of Delegates which would not be referred to Reference Committees, but received for information. The first Special Report was brought by Dr. J. W. Chambers, Coordinator of the Georgia Regional Medical Program, who gave the House of Delegates and others present an up-to-date report on the GRMP activities. Speaker Walker then recognized Dr. Earnest C. Atkins of Decatur, Chairman of the Georgia Medical Political Action Committee, who presented to the House of Delegates and other members present a Special Report on GaMPAC activities.

General Practitioner of the Year Award

Speaker Walker announced that no nominations for the 1968 Georgia General Practitioner of the Year Award were received in the Association's Headquarters prior to the opening of the Annual Session, and that consideration of a recipient of the award would be postponed until the opening of the General Business Session on Tuesday morning, May 7, at 9:00 a.m.

Chatting on the breezeway at the Augusta Town House are Irving Greenberg, Atlanta; J. G. McDaniel, Atlanta; George Alexander, Forsyth; J. W. Chambers, LaGrange; and Linton Bishop, Atlanta.

Unfinished Business

Speaker Walker announced that under the heading of unfinished business, he wished to introduce certain items of business relative to the reports in the Delegates' Folder. Dr. Walker presented the "Incoming President's Address" delivered earlier in the morning by President-Elect Charles R. Andrews, Jr.

Incoming President's Address—Reference Committee No. 3

Speaker Walker then announced that he wished to present and refer Late Reports received after the publication deadline of the Delegates' Handbook. These Late Reports as received and referred to Reference Committees are as follows:

Late Report No. 1: Third District Vice Councilor—Reference Committee No. 1

Late Report No. 2: Insurance and Economics Committee—Reference Committee No. 3

Late Report No. 3: Voluntary Health Agencies Committee—Reference Committee No. 5

Late Report No. 4: Ninth District Councilor—Reference Committee No. 5

Supplemental Reports

Speaker Walker proceeded with unfinished business, presenting Supplemental Reports for referral to House of Delegates Reference Committees. Dr. Walker stated that a Supplemental Report adds something new to an existing report previously submitted, and that he would, therefore, refer these Supplemental Reports to the same Reference Committees if they contained recommendations referred to in the original reports. The Supplemental Reports were then referred as follows:

Supplemental Report 1: MAG Council—Third Party Payments to Teaching Institutions—Reference Committee No. 3

Supplemental Report 2: MAG Council—Commercial Exhibits at Annual Sessions—Reference Committee No. 5

Supplemental Report 3: MAG Council—Central Billing—Reference Committee No. 2

Supplemental Report 4: Legislative Committee—1968 Session of the Georgia General Assembly—Reference Committee No. 2

Supplemental Report 5: Mental Health Committee—Drug Abuse—Reference Committee No. 4

Supplemental Report 6: Constitution and Bylaws Committee—Correction of Committee's Report in Handbook—Reference Committee No. 2

Supplemental Report 7: MAG Council—Headquarters Building Expansion—Reference Committee No. 3

Supplemental Report 8: MAG Council—Legal Immunity for Physicians on Utilization Review Committees—Reference Committee No. 3

New Business—Resolutions

Speaker Walker stated that at this time, the House would consider new business which concerned the introduction of Resolutions. The following Resolutions were then presented:

Resolution No. 1: Resolution of Appreciation—Preston Ellington read the Resolution and moved that it be approved by acclamation. It was duly seconded and approved by a rising vote of the House.

Resolution No. 1: Resolution of Appreciation

WHEREAS, J. Frank Walker, Jr., M.D., as a member of the Medical Association of Georgia, has given tirelessly of his time and wisdom; and

WHEREAS, He has served with dedication and distinction as Speaker of the House of Delegates of the Medical Association of Georgia for the past six years; and

WHEREAS, Doctor Walker has earned the respect and admiration of his colleagues in the House of Delegates; therefore, be it

RESOLVED: That the House of Delegates of the Medical Association of Georgia hereby expresses its deepest appreciation and gratitude to J. Frank Walker, Jr., M.D., for his inspiration and responsible leadership.

Resolution No. 2: Resolution on GaMPAC—Reference Committee No. 2

Resolution No. 3: Hospital Privileges for General Practitioners—Reference Committee No. 2

Resolution No. 4: Legislation Concerned with Licensing Clinical Laboratories and Clinical Laboratories Personnel—Reference Committee No. 2

Resolution No. 5: Annual Meeting House of Delegates—Medical Association of Georgia—Reference Committee No. 5

Resolution No. 6: Method of Electing Officers of MAG—Reference Committee No. 3

Resolution No. 7: Survey of the Practicing Physicians of Georgia—Reference Committee No. 4

Resolution No. 8: Hospital Insurance Should Not Include the Sale of Medical Services—Reference Committee No. 2

Resolution No. 9: Recognition of Physicians for Outstanding Civic Endeavor—Reference Committee No. 1

Resolution No. 10: To Continue Study of Dangerous Drugs—Reference Committee No. 4

Resolution No. 11: Physician Representation on Hospital Authorities—Reference Committee No. 2

Resolution No. 12: Abbreviated Programs of Training Radiologic Technology—Reference Committee No. 5

Resolution No. 13: Physician Representation on Hospital Governing Boards—Reference Committee No. 2

Speaker Walker then called for additional Resolutions, and there being none, the First Session of the MAG House of Delegates was recessed on motion duly made and seconded at 10:05 a.m.

Second Session, House of Delegates

Tuesday, May 7, 1968

(RECONVENED)

THE SECOND SESSION (Reconvened) of the House of Delegates of the Medical Association of Georgia held in conjunction with the 114th Annual Session of the Association was called to order by Speaker J. Frank Walker at 10:05 a.m., in the Embassy Room, Augusta Town House Motor Inn, Augusta, Georgia, on May 7, 1968.

Speaker Walker called for a report on attendance from the Credentials Committee. Dr. H. Hilt Hammett, Chairman of the Credentials Committee, reported that 113 delegates were present and registered representing 44 component county medical societies. Dr. Hammett reported that since 40 members of the House constituted a quorum, business could proceed. Dr. Walker declared a quorum present and the House of Delegates duly in session. The Credentials Committee made the following complete report on attendance at the close of the meeting.

Attendance

In a compilation of attendance taken from the official roll, 44 component county medical societies were represented by their duly elected delegates or alternates. Thirty county medical societies were not represented at this Second Session. Of a total of 162 authorized delegates from their respective medical societies, the official roll showed 113 delegates present at this Second Session.

BALDWIN: A. C. Martinez; BARROW: A. B. Russell; BEN HILL-IRWIN: H. L. Dismuke; BIBB: Charles G. Burton, Milton I. Johnson, J. G. Etheridge, Charles A. Lanford; BURKE: E. R. Hensley; CARROLL-DOUGLAS-HARALSON: J. Harvey Beall, Phil C. Astin; GEORGIA MEDICAL SOCIETY: Lee Howard, Jr., Irving Victor, John L. Elliott, J. Randall Winburn, Jr., F. Debele Maner; CHATTAHOOCHEE: Rupert H. Bramblett; CHEROKEE-PICKENS: C. J. Roper; CLAYTON-FAYETTE: Wells Riley; COBB: James H. Manning, Donald R. Rooney; DECATUR-SEMINOLE: Henry A. Bridges; DEKALB: Philip M. Jardina, W. Frank Matthews, David L. Morgan, Stanley P. Aldridge, M. Hobson Rice, Luther M. Vinton, Ellis B. Keener; DOUGERTY: Lawrence T. Crimmins; CAMDEN-CHARLTON: R. R. McCollum; EMANUEL: R. J. Moye; FLINT: J. T. Christmas; FLOYD: A. Richard Gray, James H. Smith; FULTON: W. W. Moore, J. Watts Lipscomb, F. W. Dowda, Paul A. Lavietes, Frank L. Wilson, J. G. McDaniel, J. K. Schellack, Joseph L. Girardeau, J. Rhodes Haverty, W. Perrin Nicolson, III, Elton S. Osborne, Jr., J. Frank Walker, Linton H. Bishop, Robert E. Wells, John A. Jarrell, Jr., Fleming L. Jolley, Joseph S. Wilson, James Kaufmann, John S. Atwater, Edwin C. Evans, L. Newton Turk, III, G. Lester Forbes, L. Harvey Hamff, Irving L. Greenberg, Edwin C. Pound, Jr., Harrison L. Rogers, Jr., Charles E. Todd, John N. McClure, Albert A. Rayle, Jr., J. Harold Harrison, Spencer S. Brewer, Jr., William D. Logan, Charles B. Upshaw, Jr., Edgar Woody, Jr., William L. McDougall, Jr.; GLYNN: C. S. Britt, J. L. Hunt; HABERSHAM: Thomas N. Lumsden; HALL: Robert Anderson, B. S. Hardman, C. W. Whitworth; PEACH BELT: H. E. Weems, Virgil W. McEver; JACKSON-BANKS: E. W. Holloway; MERIWETHER-HARRIS: J. Emmett Collins; MUSCOGEE: Henry H. Boyter, Luther J. Smith, II, Jack A. Raines, Jack Hirsch; OCMULGEE: W. E. Coleman; POLK: Don Schmidt; RICHMOND: Preston D. Ellington, Ronald F. Galloway, George E. VanGiesen, Daniel B. Sullivan, Henry D. Scoggins, Menard Ihnen, Stuart H. Prather, Jr., Cecil A. White, Jr., Julius T. Johnson; SCREVEN: William R. Kent, Jr.; SOUTH GEORGIA: Mack V. Greer; SOUTHEAST GEORGIA: George P. Sassos; SPALDING: Alex P. Jones, James Skinner; STEPHENS: Irving Hellenga; THOMAS-BROOKS: Robert T. Cain; TIFT: James F. Kirkpatrick; TROUP: Charles T. Cowart, H. Hilt Hammett; UPSON: T. A. Sappington; WALKER-CATOOSA-DADE: Fred H. Simonton, T. A. Cochran; WARE: F. E. Davis, L. C. Durrence; WASHINGTON: William Rawlings; WAYNE: O. O. McGahee; WHITFIELD: E. T. McGhee; WILKES: M. C. Adair.

Election of Speaker and Vice Speaker

Speaker Walker then called for an election of Speaker and Vice Speaker of the House of Delegates since the present Speaker and Vice Speaker had completed their three-year terms as prescribed in the Bylaws. Speaker Walker also explained that he had completed the maximum of two consecutive terms allowed in that office, and that it would not be possible for him to be re-elected to that position.

The Chair then called for nominations from the floor for the office of Speaker of the House of Delegates. Harrison Rogers, Jr., of Atlanta, was nominated by Walter Brown, Savannah. M. C. Adair and Robert E. Wells seconded the nomination of Harrison Rogers, Jr. On motion duly made and seconded and passed, the nominations were closed and Harri-

son Rogers, Jr., was declared elected Speaker of the House of Delegates.

The Chair then called for nominations from the floor for the office of Vice Speaker of the House of Delegates. Preston D. Ellington, Augusta, was nominated by John Rhodes Haverty of Atlanta. Fleming L. Jolley, F. W. Dowda, and Ronald Galloway seconded the nomination of Preston Ellington. On motion duly made, seconded and passed, the nominations were closed and Preston D. Ellington was declared elected Vice Speaker of the House of Delegates.

Reference Committee Reports

Speaker Rogers then called for reports from the Reference Committee Chairmen. Speaker Rogers explained to the House that reports from the Reference Committee Chairmen would be presented in the form of a motion on the floor, and if no discussion or dissent was heard when a recommendation was made by the Reference Committee, the Chair would rule the recommendation adopted as read and presented.

Report of Reference Committee No. 1

J. Harvey Beall, M.D., *Chairman*

(The following reports as presented to this Reference Committee are printed in full with the Reference Committee's recommendations and the action pursuant to them taken by the House of Delegates.)

Outgoing President John T. Mauldin presiding at the General Business Sessions.

Chairman Beall reported to the House that reports and resolutions referred to Reference Committee No. 1 were considered by the Committee which met at 2:30 p.m., Boxwood A Room, Town House Motor Inn, Augusta, on May 6, 1968. Members of the Committee present included: J. Harvey Beall, Carrollton, Chairman; Stuart H. Prather, Jr., Augusta, Vice Chairman; Robert E. Wells, Atlanta; Dan Sullivan, Augusta; and Wells Riley, Jonesboro.

President

John T. Mauldin, M.D., *Atlanta*

If one chose to look back over the past year in an effort to evaluate our activities, a number of successes, a few failures and a far greater number of compromises could be recalled. Valuable lessons result from experience and they should not be ignored. Neither should today's answers be accepted as a final answer to any particular problem. When new knowledge is developed, a new desire will almost inevitably be created. Thus, some will strive to achieve change; others will oppose it. The responsibility of the Medical Association of Georgia is neither to accept nor to oppose change. The final decision should never be based upon satisfaction with the present mechanism. Each new idea or bit of knowledge should be carefully examined for the improvement it may accomplish and in the light of the principles that have produced progress in the past.

The Advisory Committee of the Heart, Cancer and Stroke Program recently approved a request for a grant of approximately $2,000,000 for an operational program. You may recall that this program is under the supervision of MAG and has specific goals:

The first is to attempt to reduce the time lapse between discovery and utilization.

Second, to obtain cooperative arrangements for facilities and services so that they may be more generally available.

The physicians of Georgia have always been dedicated to the dispensing of the best medical care possible. However, at this time, we may have approximately $2,000,000 with which to do the job.

The medical profession is caught between two forces. Demanding costs of the governmental medical programs and the demand of the public for more medical care. It is characteristic of the American public to take anything that is free. The politicians have made medical care free to a large segment of our population. The inevitable result is an increase in demand for hospitalization, medicine, office calls, home calls, diagnostic work and so forth. If the physician meets this demand, he will be accused of running up the cost of medical care. If he judiciously refuses or fails to meet this demand, he will be damned. In meeting this situation, every effort should be made by every physician to let it be known that his fees have not been increased but that the increased cost is due to the general public's demand for additional services.

At a recent meeting in Washington of administrators of social and rehabilitation services, a great deal of time was spent discussing safeguards on utilization. This discussion centered around a recent regulation which states that by April 1, 1968, states are required to establish methods and procedures designed to safe-

guard against unnecessary utilization of health care and services as well as to assure that payments do not exceed reasonable charges and are consistent with efficiency, economy, and quality of care. This statement obviously includes physicians, office visits, office laboratory work and x-ray. In order for the administrators of social and rehabilitative services to accomplish these goals, I would not submit to an audit of my office records but would gladly explain to my peers the reason for a particular action or treatment. Several years ago, the need for auditing the reasonableness of hospitalization arose. MAG accepted this responsibility. It is now time to accept the responsibility in Title XVIII and Title XIX that physicians' charges are reasonable and necessary in relation to the illness of a particular patient.

Less than ten years ago, MAG moved into our present building. At that time, the building was quite large and everyone felt that we would be comfortable for many years to come. Today it is too small. The administration of the Heart, Cancer, and Stroke Program, along with expansion of Military Medicare, has brought us face to face with the necessity of expanding, or renting additional space, or possibly building at a new location. The recommendation of the Building Committee, under the able direction of Dr. J. G. McDaniel, should be given careful consideration.

The loss of our Executive Secretary this past year has brought sharply into focus the need to improve our staff benefits program. When interviewing individuals from other state societies, it quickly became apparent that we are far behind most other states in compensating our long term employees for their time and dedication. If we hope to keep good personnel permanently, some improvements in this area should be made immediately.

Finally, there is one problem that has been present for years and is still with us. That is the need to increase the strength and activity of our county and district medical societies. These activities should be expanded to include other than professional improvement. The county medical society can and should be a part of community activities. There should be a working relationship with the local press and the power structure of the community. This situation is not universal. A few of our county societies should be commended for their activities. However, a far greater number need to pay close attention and give a great deal of thought to expansion of their community activities.

I wish to commend every member of the staff of MAG for their dedicated service and to express my appreciation for their cooperation during the past year. It is my opinion that no state medical society has a more dedicated or a better qualified staff than MAG.

REFERENCE COMMITTEE RECOMMENDATION—We approve the report with commendation, with particular emphasis on the need of MAG to (1) improve our staff benefits programs and (2) increase the strength and activity of the county and district societies by improvement of their local society involvement in community activities. We note with interest Dr. Mauldin's reference to peer evaluation of utilization of health services. In this connection this Reference Committee recognizes the importance of Supplemental Report No. 8 which was considered by Reference Committee No. 3.

HOUSE OF DELEGATES ACTION—Adopted the report of the Reference Committee as presented.

Immediate Past President

WALTER BROWN, M.D., *Savannah*

I have attended all Executive Committee and Council meetings during the year except one. I have attended the County Officers Conference, which I feel is one of our most outstanding meetings. The programs are improving each year and I would hope that the attendance will also continue to increase.

The year 1967 saw the advent and activation of Title XIX (Medicaid) with its numerous problems to be gradually resolved.

Again I wish to express my sincere thanks and appreciation to the Association for having allowed me to have an active part in its operations, and now to step down in favor of others who have been equally as active.

REFERENCE COMMITTEE RECOMMENDATION—Your Reference Committee recommends that this report be received with approval and commendation.

HOUSE OF DELEGATES ACTION—Adopted the report of the Reference Committee as presented.

Treasurer

JOHN S. ATWATER, M.D., *Atlanta*

The report of the auditors, Ernst and Ernst, is attached. This audit covers the calendar year ending December 31, 1967. It is to be pointed out that the Association remains in good financial condition. While the overhead expenses have increased, there has also been an increase in income sufficient to meet the obligations.

I should like to thank most sincerely all those who have had a part in the conduct of this office of Treasurer, especially our most efficient bookkeeper, Miss Thelma Franklin.

ERNST & ERNST
FIRST NATIONAL BANK BUILDING
ATLANTA, GA. 30303

Chairman of the Council
The Medical Association of Georgia
Atlanta, Georgia

We have examined the statement of assets and liabilities of the several funds of The Medical Association of Georgia as of December 31, 1967, and the related statements of income and expenses and fund equities for the year then ended. Our examination was made in accordance with generally accepted auditing standards, and accordingly included such tests of the accounting records and such other auditing procedures as we considered necessary in the circumstances. While it was not practicable to confirm the amount due from the United States Government with respect to the Medicare Fund, we have satisfied ourselves as to this balance by means of other auditing procedures.

In our opinion, the accompanying statement of assets and liabilities and the statements of income and expenses and fund equities present fairly the financial position of the several funds of The Medical Association of Georgia at December 31, 1967, and the results of their operations for the year then ended, in conformity with generally accepted accounting principles applied on a basis consistent with that of the preceding year.

Ernst & Ernst

Atlanta, Georgia
March 1, 1968

STATEMENT OF ASSETS AND LIABILITIES—BY FUNDS

THE MEDICAL ASSOCIATION OF GEORGIA

December 31, 1967

ASSETS

GENERAL FUND			
Cash:			
Demand deposits		$ 20,374.82	
Savings deposits:			
Restricted	$16,000.00		
Unrestricted	90,000.00	106,000.00	$126,374.82
Accounts receivable:			
Advertisers of The Journal		$ 2,695.00	
Due from Old Age Assistance Program		991.23	
Excess of claim expenses incurred over claim fees received—United States Government—Medicare		16,817.36	20,503.59
Other assets			835.00
Property and equipment—on the basis of cost:			
Buildings—mortgaged		$ 94,454.72	
Furniture and equipment		28,018.94	
		$122,473.66	
Less allowances for depreciation		68,278.17	
		$ 54,195.49	
Land—mortgaged		80,000.00	134,195.49
			$281,908.90
ABNER W. CALHOUN LECTURESHIP FUND			
Cash		$ 130.46	
Corporation stocks (quoted market prices $4,288.00)—at cost		5,897.03	6,027.49
MEDICARE FUND—DEPARTMENT OF THE ARMY			
Cash		$ 97,205.67	
Due from United States Government—service fees paid to physicians and dentists		27,794.33	125,000.00
			$412,936.39

LIABILITIES AND EQUITIES

GENERAL FUND		
Liabilities:		
5% note payable to insurance company, due on January 1, 1969—land and building mortgaged as collateral		$ 3,000.00
Excess of advances received over expenses—Georgia Regional Medical Program		9,037.64
Advance collections:		
1968 membership dues	$ 417.50	
1968 exhibit space payments	3,500.00	3,917.50
Fund equity:		
Restricted:		
Regular operating purposes	$ 20,000.00	
Lecture expenses	565.49	
	$ 20,565.49	
Unrestricted	245,388.27	265,953.76
		$281,908.90
ABNER W. CALHOUN LECTURESHIP FUND EQUITY		6,027.49
MEDICARE FUND—DEPARTMENT OF THE ARMY		
Advance from United States Government		125,000.00
		$412,936.39

STATEMENT OF FUND EQUITIES

THE MEDICAL ASSOCIATION OF GEORGIA

Year ended December 31, 1967

	Balance Jan. 1, 1967	*Excess of Income Over Expenses*	*Fund Transfers*	*Balance Dec. 31, 1967*
GENERAL FUND				
Restricted for operating purposes	$ 20,000.00	$ -0-	$ -0-	$ 20,000.00
Restricted for lecture expenses	414.04	-0-	151.45	565.49
Unrestricted	221,674.96	23,713.31	-0-	245,388.27
	$242,089.00	$23,713.31	$151.45	$265,953.76
ABNER W. CALHOUN LECTURESHIP FUND	5,979.99	198.95	151.45*	6,027.49
TOTAL	$248,068.99	$23,912.26	$ -0-	$271,981.25

* Indicates red figure.

STATEMENT OF INCOME AND EXPENSES—BY FUNDS

THE MEDICAL ASSOCIATION OF GEORGIA

Year ended December 31, 1967

	General Fund	*Abner W. Calhoun Lectureship Fund*
INCOME		
Medical Association of Georgia dues	$120,900.00	$ -0-
Advertising—The Journal	56,748.30	-0-
Subscriptions—The Journal	1,611.30	-0-
Exhibitors fees—1967 annual meeting	9,425.00	-0-
Interest income	7,673.37	-0-
Dividends—corporate stocks	-0-	256.92
American Medical Association refund	2,124.30	-0-
Miscellaneous	116.17	-0-
TOTAL INCOME	$198,598.44	$256.92
EXPENSES		
Fixed allotments	$ 13,794.85	$ -0-
Association office	123,082.58	-0-
Association boards	14,478.34	-0-
Related Association activities	744.99	-0-
Contingent fund	6,365.47	-0-
The Journal	44,835.13	-0-
Trustees fees and expenses	-0-	57.97
Recovered expenses	28,416.23*	-0-
TOTAL EXPENSES	$174,885.13	$ 57.97
EXCESS OF INCOME OVER EXPENSES	$ 23,713.31	$198.95

* Indicates red figure.

REFERENCE COMMITTEE RECOMMENDATION—Your Reference Committee recommends approval and commendation of this report with recognition of the sound financial condition of the Medical Association of Georgia.

HOUSE OF DELEGATES ACTION—Adopted the Reference Committee recommendation as presented.

Alternate Delegate

F. William Dowda, M.D., *Atlanta*

I was an AMA Alternate Delegate during the past year. It has been my privilege to serve with what I consider to be one of the finest teams of men in organized medical activities today.

Headed up by Dr. J. W. "Red" Chambers, my delegation has established an outstanding reputation for itself. I believe, however, that our delegation has been able to make such an outstanding reputation for itself because of its dedication to the philosophy that the patient's welfare and care must come first above all things and secondly, that in order to maintain the best possible patient care available, physicians themselves must be free. Sometimes this particular philosophic approach required sacrifice, financial loss and occasionally acceptance of abuse from politicians and the public. However, I am convinced that if this House of Delegates will reaffirm its dedication to these principles of the provision of the best possible health care and the maintenance of freedom of patients and physicians that they will in the long run overcome their opposition because they are dedicated to what is right.

Mrs. Clyde A. Burgamy of Augusta models one of the "fashions in politics" presented by the Richmond County Woman's Auxiliary.

REFERENCE COMMITTEE RECOMMENDATION—Your Reference Committee recommends approval and commendation of this report with emphasis on the last sentence "that if this House of Delegates will reaffirm its dedication to these principles of the provision of the best possible health care and the maintenance of freedom of patients and physicians that they will in the long run overcome their opposition because they are dedicated to what is right."

HOUSE OF DELEGATES ACTION—Adopted the recommendation of the Reference Committee as presented.

Second District Councilor

J. D. Bateman, M.D., *Albany*

Counties and Secretaries	Members December 31, 1967 MAG	Members December 31, 1967 AMA Dues Paying Only	Members December 31, 1966 MAG	Members December 31, 1966 AMA Dues Paying Only
Colquitt Walter E. Harrison Moultrie	15	14	15	14
Decatur-Seminole C. G. Belleville Bainbridge	18	10	15	11
Dougherty M. S. Buckner Albany	60	47	58	45
Grady C. K. Singleton Cairo	5	5	5	5
Mitchell A. A. McNeill Camilla	7	6	7	6
Southwest Georgia R. E. Jennings Arlington	13	12	14	13
Thomas-Brooks D. J. McKenzie Thomasville	43	37	44	38
Tift H. K. Jarrett Tifton	18	13	18	13
Worth R. T. Morgan Sylvester	5	5	6	6
	184	149	182	151

REFERENCE COMMITTEE RECOMMENDATION —Your Reference Committee recommends approval of this report.

HOUSE OF DELEGATES ACTION—Adopted the Reference Committee recommendation as presented.

Third District Councilor

J. T. Christmas, M.D., *Vienna*

The Third District Councilor has attended and participated in all regular and called meetings of the Council during the past year. The Third District has held two regular District Meetings this year. The Spring Meeting was held on April 26, 1967 in Americus and the Fall Meeting was held in October in Montezuma. Excellent scientific programs were presented at both meetings, but for some reason the attendance at these District meetings continues to be poor.

In addition to the above meetings, this Councilor attended the Leadership Conference for County Societies' officers in Atlanta on Feb. 3-4, 1968. I was equally impressed with the poor attendance at this meeting.

It seems to me that the most pressing need now facing MAG is a better motivation of members to actively participate in the activities of the Association. This need would appear to be multiplied by the ever growing trend toward complete socialization. Mailing the highlights of the Council and Executive Committee meetings to each County Society was an effort to bring about a closer liaison between the local Society and the State office. This has undoubtedly helped. The hiring of a field man was one of the best moves made yet to strengthen MAG, but this office has not yet had time to "catch up the slack."

While I have no earth shaking suggestions to make, it seems to me that one thing that might help stimulate more interest in the membership would be a regular visitation of the various County Societies by the District Councilor.

Counties and Secretaries	Members December 31, 1967 MAG	Members December 31, 1967 AMA Dues Paying Only	Members December 31, 1966 MAG	Members December 31, 1966 AMA Dues Paying Only
Flint C. C. Goss Ashburn	13	10	12	11
Peach Belt Frank Vinson Fort Valley	32	30	31	29
Randolph-Stewart-Terrell Mack Allen Dawson	14	11	14	12
Sumter W. R. Anderson Americus	21	17	22	20
Taylor E. C. Whatley Reynolds	3	2	3	3
	83	70	82	75

REFERENCE COMMITTEE RECOMMENDATION —Your Reference Committee recommends approval and commendation of this report with the recommendation that district society dues be included on the county society dues statement.

HOUSE OF DELEGATES ACTION—Adopted the Reference Committee recommendation as presented.

Seventh District Councilor

Ralph N. Johnson, M.D., *Rome*

Counties and Secretaries	Members December 31, 1967 MAG	Members December 31, 1967 AMA Dues Paying Only	Members December 31, 1966 MAG	Members December 31, 1966 AMA Dues Paying Only
Bartow V. D. Hamilton Cartersville	9	7	9	6
Carroll-Douglas-Haralson Edwin H. Grant Carrollton	33	30	35	31
Chattooga William Hyden Trion	5	5	6	6
Floyd H. R. Connell Rome	77	65	72	64
Gordon B. H. Steele Fairmont	10	9	10	9
Polk John McGehee Cedartown	14	12	13	11
Walker-Catoosa-Dade Sara L. Goolsby Rossville	31	16	32	20
Whitfield R. E. Bowers Dalton	39	34	40	35
	218	178	215	182

REFERENCE COMMITTEE RECOMMENDATION— Your Reference Committee recommends approval of this report.

HOUSE OF DELEGATES ACTION—Adopted the Reference Committee recommendation as presented.

Tenth District Councilor

William Rawlings, M.D., *Sandersville*

The Tenth District has missed the leadership of Dr. Addison Simpson from the field of organized medicine due to his untimely death. We all appreciate the fine job he did to further the aims of medicine during his professional life. The Vice-Councilor, Dr. William Rawlings, has been elected to serve the remaining portion of Dr. Addison Simpson's term which expires in 1969.

During this year, the Tenth District has had its fall meeting in Washington, Georgia. The Washington-Wilkes Medical Society was our host and an excellent program was presented. The spring meeting was held in Milledgeville in April. Your Councilor has attended all Council meetings except one, and this was because of illness.

A Paramedical Recruitment Committee has been formed in this District, and this is headed by Dr. Walter Shepeard of Augusta. A good number of county societies have rendered names to form this committee and

those who have not have been urged to do so. The Paramedical program, as well as the Auto Safety program, have been brought to the attention of the respective societies.

Counties and Secretaries	Members December 31, 1967 MAG	Members December 31, 1967 AMA Dues Paying Only	Members December 31, 1966 MAG	Members December 31, 1966 AMA Dues Paying Only
Baldwin Mahmud Majanovic Milledgeville	30	23	32	24
Crawford W. Long R. E. Banister Athens	58	48	57	50
Jasper Ben C. Barrow Monticello	3	3	3	3
Jefferson W. J. Revell Louisville	5	4	5	5
McDuffie T. W. Middlebrooks Thomson	6	6	5	5
Newton-Rockdale R. L. Faulkner Covington	13	8	13	8
Oconee Valley Leo J. Wade Union Point	11	8	11	8
Walton R. M. Tankesley Monroe	10	8	10	8
Washington D. L. Holmes Sandersville	12	1	12	7
Wilkes A. D. Duggan Washington	6	5	8	7
	154	114	156	125

REFERENCE COMMITTEE RECOMMENDATION—We recommend approval and commendation of this report with special recognition of the formation of the paramedical recruitment committee and the auto safety program.

After his election as Speaker of the House of Delegates, Harrison Rogers of Atlanta (right) joined Ed Smith, MAG Executive Secretary; J. Rhodes Haverty, Secretary; and John Mauldin, President, at the speakers' table on the stage.

HOUSE OF DELEGATES ACTION—Adopted the Reference Committee recommendation as presented.

Bibb County Councilor

BRASWELL E. COLLINS, M.D., *Macon*

The Bibb County Medical Society has had a successful year of community service and society programs.

Our membership has remained about the same.

The January program as usual was devoted to the relationship of medicine and religion.

The April program featured the Mike Whitman Memorial lecture presented by Andrew Wallace, M.D., Duke University. He spoke on "Advances in Cardiac Care and the Coronary Care Unit" at Duke University. Dr. Wallace complimented the staff of the Macon Hospital for its superior coronary care unit.

There are no recommendations for the House of Delegates at present.

Counties and Secretaries	Members December 31, 1967 MAG	Members December 31, 1967 AMA Dues Paying Only	Members December 31, 1966 MAG	Members December 31, 1966 AMA Dues Paying Only
Bibb Charlotte Neuberg Macon	178	157	184	164

REFERENCE COMMITTEE RECOMMENDATION—Your Reference Committee recommends approval and commendation of this report.

HOUSE OF DELEGATES ACTION—Adopted the Reference Committee recommendation as presented.

DeKalb County Councilor and Vice Councilor

FLOYD R. SANDERS, M.D., *Decatur,* Councilor
M. FREEMAN SIMMONS, M.D., *Decatur,* Vice Councilor

During the past year the DeKalb County Medical Society has continued to increase in membership and the phenomenal growth of this area's population has placed added responsibility on every member of the society. A major function of the executive secretary of the society is helping new citizens of the community find medical care.

In addition to their medical activities members of the society are active in all phases of community life. During recent months the requests and demands for advice, financial help and personal participation in matters not specifically related to medicine seem to have come to the society in ever increasing numbers. The society has made every effort to satisfy all reasonable requests.

All hospitals and clinics in the county are operating at full capacity plus, with "on call" lists getting longer every day. DeKalb General Hospital expects to begin its long awaited expansion program this year, and will include a Long Term Care unit and a Mental Health unit in addition to doubling the bed capacity for acute cases.

It has been our pleasure to represent the DeKalb County Medical Society at all Council meetings during the year, and we, along with all our society members, shall continue to support the Medical Association of Georgia in every possible way.

Counties and Secretaries	Members December 31, 1967 MAG	Members December 31, 1967 AMA Dues Paying Only	Members December 31, 1966 MAG	Members December 31, 1966 AMA Dues Paying Only
DeKalb				
F. E. Morgan				
Decatur	181	160	163	152

REFERENCE COMMITTEE RECOMMENDATION—Your Reference Committee recommends approval of this report with commendation.

HOUSE OF DELEGATES ACTION—Adopted the Reference Committee recommendation as presented.

Georgia Medical Society Councilor

LEE HOWARD, JR., M.D., *Savannah*

This, my first year as a member of Council, has been most instructive. I have been greatly impressed by the dedication of the officers of the MAG and the members of Council, as well as by the efficiency of the Headquarters Staff.

I have nothing that I wish to submit to the House of Delegates.

Counties and Secretaries	Members December 31, 1967 MAG	Members December 31, 1967 AMA Dues Paying Only	Members December 31, 1966 MAG	Members December 31, 1966 AMA Dues Paying Only
Georgia Medical Society				
Jeff J. Holloman				
Savannah	165	148	160	143

REFERENCE COMMITTEE RECOMMENDATION—We approved this report with commendation.

HOUSE OF DELEGATES ACTION—Adopted the Reference Committee recommendation as presented.

Muscogee County Councilor

LUTHER H. WOLFF, M.D., *Columbus*

The Councilor from the Muscogee County Medical Society has been engaged in the usual routine activity of attending Council meetings and reporting pertinent data to the Muscogee County Medical Society.

Further government intrusion into medical care seems inevitable. The next phases will probably place all children under a Medicare type program and the freezing of fees is certainly an imminent threat. The officers, the council, and the members of the Association should be alert for these socializing trends and should be prepared to oppose them with all our strength and vigor.

Counties and Secretaries	Members December 31, 1967 MAG	Members December 31, 1967 AMA Dues Paying Only	Members December 31, 1966 MAG	Members December 31, 1966 AMA Dues Paying Only
Muscogee				
W. W. Ausbon				
Columbus	119	106	122	109

REFERENCE COMMITTEE RECOMMENDATION—Your Reference Committee recommends approval and commendation of this report.

HOUSE OF DELEGATES ACTION—Adopted the Reference Committee recommendation as presented.

Cancer

HOKE WAMMOCK, M.D., *Chairman*

At the beginning of the year, Secretary Rhodes Haverty wrote a letter to each Committee Chairman that he commit to writing the purpose and goals of his particular committee.

We have endeavored to comply with this request. With this commitment, the Committee on Cancer set forth our purpose and goal—for the continued development and strengthening of the State Aid Cancer Clinics and their programs.

The function of the Committee on Cancer has been in the capacity of an advisory committee to the State Public Health Department and its State Aid Cancer Control Program. In 1937 by legislative act the State Aid Cancer Program for aid to the indigent patient and the establishment of State Aid Cancer Clinics, based on the rules and regulations set forth by the Cancer Commission of the American College of Surgeons, was begun.

The Cancer Act was abolished in 1962 when the Public Health Code was rewritten. Nevertheless, the Public Health Department has continued its State Aid Cancer Control Program.

The past year has been rather eventful. There have been some obstacles to combat, yet with it all, there is a bright horizon. First, the Medicare program was activated in July 1966 and the Medicaid program was begun in October 1967.

The Medicaid and Medicare programs resulted in reduction of patient load in some clinics. As a matter of fact, some clinics closed, due to the fact that some of the indigent patients became potential private patients. In addition to the reduction of the patient load there appeared to be some drop in the interest by the clinic staff in the Cancer program.

The bright side of the picture has been the progress made by the Georgia Regional Medical Program in Cancer.

In May 1967 a Task Force was selected to study and make recommendations for Cancer Control. This committee has made a state-wide survey of all cancer facilities, both physical and personnel and has made recommendations to the steering committee of the Georgia Regional Medical Program. The cancer clinics have made it possible for the Task Force to progress so rapidly in the past few months.

On August 14, 1967, the Tumor Clinic Directors were invited to meet with the Task Force for the purpose of open discussion of the cancer problems as related to the respective clinics throughout the state.

It was the theme of this meeting that the cancer clinic should make every effort for improvement by developing specific programs for participation in the Georgia Regional Medical Program.

Later on during the year, on November 17, there was a special meeting of the Committee on Cancer for the purpose of discussing the State Aid Cancer Program and the effect of Medicare and Medicaid patients on the Tumor Clinics. Those present were Dr. John Venable, Director of the State Public Health Department and Dr. Carl Sessions, Director of the Cancer Control Division of the State Health Department, Dr. Robert R. Smith, Associate Director of the Georgia Regional Medical Program, Dr. A. H. Letton and Dr.

Charles Huguley, Co-Chairmen of the Task Forces of the Georgia Regional Medical Program.

This meeting was urgent in view of the fact that a couple of the clinics had closed as a result of reduction in their case load. There were other clinics that apparently had suffered considerable reduction in patients. It was emphasized at this meeting that there would still be a large number of indigent patients despite Medicaid and Medicare. Further emphasis was placed upon the role of the Regional Medical Program in cancer, and it was emphasized that there was a need for area cancer facilities and that the clinics should make every effort to remain open and continue their service, not only for the indigent patient, but also for the private patient, as the clinic serves as a common denominator for cancer control. Dr. Venable stated that patients over 21 and under 65 are still going to need care in the cancer clinics because they do not qualify for either Medicare or Medicaid.

It must be pointed out that with the operation of the Georgia Regional Medical Program this is a golden opportunity for physicians to plan and develop their own program of medical care, particularly with respect to the State Aid Cancer Clinics in Georgia because they can serve as a nucleus to build a strong cancer program. If we, as physicians, do not take this opportunity then the decision will be made by someone else. We therefore urge all to seek ways and means of continuing operation of the cancer clinic throughout the state by improving the service, developing physician interest in cancer and molding a program to be surpassed by none.

The ultimate goal of the Georgia Regional Medical Cancer Program is to reduce suffering, disability and death from cancer by promoting opportunity for physicians to be competent in the detection and treatment of cancer, and for patients to receive the latest advances in diagnosis and treatment of cancer.

The program will be built around *area cancer facilities.*

REFERENCE COMMITTEE RECOMMENDATION—Your Reference Committee recommends that this report be approved with commendation and with special notice of Dr. Wammock's appeal that existing cancer clinics be supported and become stronger rather than obsolete under the new proposed programs, one of which will be the Georgia Regional Medical Program.

HOUSE OF DELEGATES ACTION—Adopted the Reference Committee recommendation as presented.

Report of the Journal

EDGAR WOODY, JR., M.D., *Editor*

The 1967-68 report of the *Journal of the Medical Association of Georgia* is submitted herewith.

PERSONNEL

During the year just past Miss Merrilie Davis submitted her resignation as Managing Editor in order to accept a position with a hotel chain. Her resignation was accepted with regret since she had served the *Journal* well for five years. Our good wishes go with her in her new position.

We have been most fortunate to secure Miss Frances Shinnick as our new Managing Editor. Miss Shinnick is a graduate of Hollins College and brought with her one year's experience in the editorial field prior to coming with the *Journal* in June of 1967. Her work has been of the highest caliber, and it is hoped that her tenure will be long.

STATE MEDICAL JOURNAL ADVERTISING BUREAU

The Managing Editor and the Editor attended a meeting in Chicago in September 1967 sponsored by the State Medical Journal Advertising Bureau. This meeting is held every other year and is quite helpful as an informational and training seminar for all of the state editors. At this meeting optimism was expressed for a gradual increase in advertising volume. These increases are made possible by the very active sales force now employed by the Bureau. All things considered, it was an encouraging and informative session for the delegates from the state journals.

ADVERTISING

As mentioned above our national advertising volume has shown a gradual increase over the past twelve months while our local advertising has remained about stable. This gradual increase in volume has made it possible to print an additional scientific paper each month and to cover the activities of the Association more completely.

COST CONTROL

Our *Journal* editorial content has been effectively controlled to balance with our advertising volume. Since this volume fluctuates frequently, control is effected on a month-by-month basis and has proven effective in keeping within our budget.

CREDITS

An expression of gratitude is due the members of the Publications Committee for their wise counsel and help in dealing with our *Journal* problems during the past year. Our Contributing Editors have been an invaluable help in carrying on the work of the *Journal.* One of our most active Contributing Editors, Dr. Thomas Findley of the Medical College of Georgia, has recently accepted a position as Visiting Professor of Medicine at the University of Taiwan for a period of two years. His frequent contributions will certainly be missed. Our President's Page during the past twelve months has been outstanding and much credit is due him for his contribution to the *Journal.* The editors and contributors of our specialty pages have been very cooperative in supplying timely material. Their efforts are much appreciated.

Last, but by no means least, the continued contributions of the Headquarters Office Staff must be pointed out and commended. Their continued help and cooperation have been vital in the publication of the *Journal.*

REFERENCE COMMITTEE RECOMMENDATION—We recommend that this report be approved with high commendation of the many years of effort Dr. Woody has brought to this excellent endeavor, and we note with regret the resignation of Miss Shinnick from the staff.

HOUSE OF DELEGATES ACTION—Adopted the Reference Committee recommendation as presented.

Georgia Regional Medical Program

J. W. Chambers, M.D., *Program Coordinator*

As the Members of this House will recall, at the time of your Annual Meeting last year in May 1967, the Georgia Regional Medical Program was indeed an infant. At that time we were in the process of assembling a staff and getting them moved into space on the second floor of the MAG Headquarters building. Since that time under the most able direction of J. Gordon Barrow, M.D., as Program Director, the infant has grown to be at least a viable and vigorous teenager if not a young adult. For the benefit of any members of the House who were not present last year let me give a very brief background summary.

This program began in this state as a region before the enabling law (Public Law # 89239) was passed. Under the leadership of George Alexander, M.D., then President of MAG, the Board of Medical Education of the MAG, Arthur Richardson, M.D., Dean of Emory School of Medicine, and his associates, and Harry O'Rear, M.D., President of the Medical College of Georgia, and his associates, discussions of the possible legislation and its effect on Georgia were begun. These were expanded shortly to include the Georgia Heart Association, the Georgia Division of the American Cancer Society, the Georgia Hospital Association. Subsequently these discussions were quickly enlarged to include representatives of all the oriented groups and a loosely organized plan was formed to set up a Regional Advisory Group which was required by the law as it was finally passed in October 1965.

The purpose of Public Law #89239 under which this program functions can best be expressed in the following quote from the law itself. "(A) To encourage and assist in the establishment of Regional Cooperative Arrangements among medical schools, research institutions, and hospitals for research and training including continuing education and for related demonstrations of patient care in the fields of heart disease, cancer, stroke, and related diseases; (B) to afford to the medical profession and the medical institutions of the nation through such cooperative arrangements the opportunity of making available to their patients the latest advances in the diagnosis and treatment of these diseases; and, (C) by these means to improve generally the health, manpower, and facilities to the nation and to accomplish these ends without interfering with the patterns or the methods of financing of patient care, or professional practice or the administration of hospitals and in cooperation with the practicing physicians, medical center officials, hospital administrators, and representatives from appropriate voluntary health agencies."

This in plain language gives us an opportunity to participate in this Federally Financed Program but locally from the grass roots to determine what shall be done.

In the summer of 1966 the Regional Advisory Group was formed and a Steering Committee was designated consisting of: J. Willis Hurst, M.D., Chairman; Robert L. Brown, M.D.; J. Gordon Barrow, M.D.; Raymond Ahlquist, Ph.D.; and Louis L. Battey, M.D. This group was requested to draft a proposed planning grant application which they did at a great sacrifice of much time and effort in time for the application to be submitted on September 24, 1966. At the time the planning grant application was finally voted on in September 1966 by the Regional Advisory Group, the Medical Association of Georgia offered and was accepted as the applicant or fiscal agent for the Georgia Regional Program. The undersigned was designated by the Council of MAG and the Regional Advisory Group as Program Coordinator and Ex-Officio Member of the Steering Committee. Later when we prevailed upon Dr. Barrow to become the full-time Pro-

Mrs. Luther Vinton of Decatur, GaMPAC Co-Chairman, Earnest Atkins of Decatur, GaMPAC Chairman, and Luther Vinton of Decatur, Annual Session Chairman, at the GaMPAC registration table.

gram Coordinator he became an Ex-Officio Member of the Steering Committee, and J. B. Ellison, M.D., of the Georgia State Medical Society was elected a Member of the Steering Committee. Since May 1967, due to the hard work of the Steering Committee, Dr. Barrow, and the full-time staff and the members of the task forces, the program has developed at an amazing pace. The Regional Advisory Group as finally organized is composed of approximately 125 practicing physicians, nurses, dentists, pharmacists, medical college officials, hospital administrators, representatives of appropriate medical societies, other health professions, voluntary health agencies, and members of the public who are knowledgeable of health needs and problems.

A unique feature of our Georgia Program is the appointment by each local hospital in the state through its medical staff and administration of a local advisory group to advise on local needs. The chairman of the local group must be the chief of staff or his designate. This has been done by hospitals representing over 90 per cent of the hospital beds in this state or region. The chairmen of these local groups met in Atlanta on June 4, 1967, for their organization and orientation. Under the by-laws of the Regional Advisory Group they must meet twice each year.

In the short space of time since May 1967, Dr. Barrow and the Steering Committee have organized 14 task forces that are functioning and have made reports and recommendations to the Regional Advisory Group. With only one or two exceptions these recommendations have been processed by the chairmen of the task forces as a coordinating task force and subsequently passed on by the Steering Committee and the Regional Advisory Group. These now have been developed into an operational grant application as of February 29, 1968. To give you details of this application in this short report would be much too lengthy; as much detail as desired will be given to the designated Reference Committee of this House.

To understand the gigantic task as presented in this program as of January 1, 1967, and the job that has been accomplished as of now is almost unbelievable. This could only be fully appreciated by spending some time with the Steering Committee and the Staff who have worked long and overtime hours as a dedicated work force.

I believe, Mr. Speaker, that the Georgia Regional Medical Program is an endeavor that the Medical Association of Georgia can take great and just pride in.

REFERENCE COMMITTEE RECOMMENDATION—Your Reference Committee recommends approval of this report with commendation and with particular emphasis on the need for more awareness on the part of the individual physician of the purposes of the Georgia Regional Medical Program as noted by Dr. Chambers in his recommendation that each member read Public Law 89-239. We recommend further explanations of the program be published in the *Journal of the Medical Association of Georgia.*

HOUSE OF DELEGATES ACTION—Adopted the Reference Committee recommendation as presented.

Christian Ramsey, president of the Student American Medical Association Chapter at Emory as well as national vice president of SAMA, addresses the House of Delegates.

Late Report No. 1

REPORT OF VICE COUNCILOR—THIRD DISTRICT

JOHN H. ROBINSON, III, *Americus*

During my first year as Vice Councilor from the Third District, I have attended the meetings at Sea Island and Valdosta and plan to attend the meeting in Atlanta in March. I have been amazed at the amount of business that comes before the Council.

REFERENCE COMMITTEE RECOMMENDATION—Your Reference Committee recommends that this report be approved.

HOUSE OF DELEGATES ACTION—Adopted the Reference Committee recommendation as presented.

Resolution No. 9

RECOGNITION OF PHYSICIANS FOR OUTSTANDING CIVIC ENDEAVOR

ALEX P. JONES, M.D.,
For Spalding County Medical Society

PREAMBLE: The House of Delegates of the Medical Association of Georgia selects the recipient of the General Practitioner of the Year from nominations submitted by county medical societies. This award, as probably it should be, has usually been awarded to the oldest and most respected nominee. Awards are made to the outstanding teacher or researcher in a similar manner. However, there are many physicians in the Medical Association of Georgia who contribute much in the field of public service or perform some outstanding service in their community and yet these physicians are not given any recognition by the House of Delegates of the Medical Association of Georgia. The members of the Spalding County Medical Society, recognizing the need for an award for such service, submit the following resolution for

the consideration of the House of Delegates of the Medical Association of Georgia at the next annual meeting.

WHEREAS, there are many physicians in the state of Georgia who contribute a considerable amount of their time and energies in public service and civic activities; and

WHEREAS, these physicians, through their activities, do much to enhance the image and stature of every member of the Medical Association of Georgia; and

WHEREAS, these physicians are not given appropriate recognition for the activities and contributions by the House of Delegates of the Medical Association of Georgia.

THEREFORE BE IT RESOLVED, that Spalding County Medical Society requests that the House of Delegates, at their next annual meeting, consider the creation of a suitable award and plaque which will be presented each year to outstanding physicians in this state who have made outstanding contributions through public service or civic activities.

AND BE IT FURTHER RESOLVED, that election of recipients be made by the House of Delegates based on nominations and summaries of activities which have been submitted by component medical societies.

AND BE IT FURTHER RESOLVED, that recipients be presented their plaque and award at each annual meeting of the House of Delegates when the other awards are presented.

REFERENCE COMMITTEE RECOMMENDATION—Your Reference Committee recommends approval of the resolution with the following clarifying amendments: (1) that line 13 be changed to read "to an outstanding physician in this state who has made outstanding contributions" and (2) that lines 15-17 be changed to read "AND BE IT FURTHER RESOLVED, that selection of the recipient be made by a three-man secret committee, not necessarily physicians, appointed by the president at his discretion, based on nominations and summaries of activities which have been submitted by the county medical societies."

HOUSE OF DELEGATES ACTION—Adopted the Reference Committee recommendation as presented.

Dr. Beall stated that he wished to honor and recognize the authors of these reports, especially the gentlemen who have provided faithful and devoted service to MAG and the profession down through the years.

Dr. Beall then reported that this concluded the report of the Reference Committee No. 1, and moved for the adoption of his report as a whole with appreciation to the members of his Committee. This motion was duly seconded and approved.

Report of Reference Committee No. 2

A. P. Jones, M.D., *Chairman*

(The following reports as presented to this Reference Committee are printed in full with the Reference Committee's recommendations and the action pursuant to them taken by the House of Delegates.)

Chairman Jones reported to the House that reports and resolutions referred to Reference Committee No. 2 were considered by the Committee which met at 2:30 p.m., Boxwood B Room, Town House Motor Inn, Augusta, on May 6, 1968. Members of the Committee present included: A. P. Jones, Griffin, Chairman; James H. Smith, Rome, Vice Chairman; Joseph A. Mulherin, Savannah and R. J. Moye, Swainsboro.

Speaker, House of Delegates

J. Frank Walker, M.D., *Atlanta*

The multiple actions of the 1967 House of Delegates of the Medical Association of Georgia (Atlanta, May 1-2) were referred by your Speakers to the appropriate bodies within the Association for implementation. These actions were published in the Proceedings of the House, *Journal of the Medical Association of Georgia.*

After policies are set by the House, your Speakers carefully check progress on the items during the year to follow through on implementation. As of this date, all actions have been completed or are well along in the process of completion or continuing action by the Council, its Executive Committee or by appropriate MAG Committee. In this way, the "will of the House" is accomplished.

Your Speakers, in your behalf, have attended the meetings of the MAG Council; and, in addition, the Speaker represents the interests of the Delegates, and those whom they represent, at meetings of the Executive Committee of Council.

We believe that innovations instituted through the years have resulted in a more efficient, responsible and representative House. Attendance at the important second "voting" session of the House improved after closure of the time gap between the two sessions. Quite successful, last year, was the provision of full-time staff assistance for each Reference Committee. Geographical alignment of the Reference Committees has expedited their work and has been of convenience for

J. Frank Walker of Atlanta, outgoing Speaker of the House of Delegates, receives a gift presented by Thomas Goodwin of Augusta, the only other past Speaker, in appreciation of his service to the Association.

officers and members who must and should appear before the Committees. Annotation is the next forward step. Attempts to divide equally the work of the Reference Committees continues, although inexactly, because of the nature of the topics. The present state of House organization reflects the advice and assistance of California-departed Milton Krueger.

Your Speakers are charter life-time members of the Southeastern Speakers Conference, the organizational meeting of which we attended in New Orleans last spring.

I retire as your Speaker at this Session of the House. Thank you each for allowing me this honor, responsibility and privilege for so many years. I shall now join the select group of past Speakers, a large organized group of just Tom Goodwin of Augusta and me.

You will elect a new Speaker and Vice Speaker at the second session of the House of Delegates this year.

I give thanks for the able and faithful assistance and counsel, through the years, of Vice Speakers, the late Joe Mercer and, presently, Harrison Rogers.

REFERENCE COMMITTEE RECOMMENDATION—This report is approved with commendation and the Committee would like to call particular attention to the innovative addition of "numbered lines" on Resolutions, Supplemental Reports and Late Reports as these will facilitate the business of the House of Delegates in an orderly manner.

HOUSE OF DELEGATES ACTION—Adopted the Reference Committee recommendation as presented.

AMA Delegates

J. W. Chambers, M.D., *La Grange, Chairman*
John S. Atwater, M.D., *Atlanta*
J. Frank Walker, M.D., *Atlanta*
Preston D. Ellington, M.D., *Augusta*

As Chairman of the MAG Delegation to the AMA House of Delegates, I am again pleased to report to this House that the MAG has been represented by a full delegation, both at the annual AMA Meeting at Atlantic City, New Jersey, and at the Clinical Session in Houston, Texas. At each of these meetings every Reference Committee was covered by your representatives, who were both knowledgeable and articulate.

We have continued our custom in the MAG Delegation begun many years ago of meeting for breakfast before the first day of meetings of the Reference Committees to discuss each item of business so that your MAG Representatives who attend each Reference Committee are informed as to MAG policy and there is a consensus of opinion in the Delegation on items to come before each Reference Committee. Again, we meet after the Reference Committee discussions and the Reference Committee reports are available so that your Delegates on the floor of the AMA House have the combined opinions of the discussions of the Alternate Delegates and your own officers of the MAG.

At the Annual Meeting in Atlantic City, New Jersey, a resolution introduced at the request of this House was not recommended favorably, but subsequently after debate on the floor by your delegation the resolution was adopted as introduced. This was Resolution #39 of the AMA House.

This was a very busy session of the AMA House since in addition to the normal committee and council reports there were 118 resolutions introduced to be discussed and acted upon. Many of the resolution were related to recommendations about many phases of titles #18 and #19 of the Medicare Law (PL 89-97), for additional safeguards to patients, physicians, and hospitals.

The Clinical Session in Houston, Texas, was an equally busy session, there being some 37 board and council reports and 58 resolutions. There were several actions passed of special interest in this House of Delegates. First, I am proud to report as a result of the efforts of your Delegation, the MAG Staff and Council, the Fulton County Medical Society, and the Atlanta Convention Bureau, that the Board of Trustees of the AMA recommended and the AMA House adopted the recommendation that Atlanta be the site of the 1972 Clinical Session of the AMA.

Also at this session the Fulton County Society was commended by Reference Committee (C) for their innovative efforts in developing joint meetings of medical staffs and the county medical society. There was a great deal of discussion in Reference Committee (A), much of it led by members of your Delegation in regards to Report (B) of the AMA Council on Medical Service relative to Medical Society participation in government medical care programs. This report was referred back to the AMA Council on Medical Service for further study and report to be presented again to the AMA House at the San Francisco Meeting in June 1968. Since MAG has so much firsthand knowledge of these programs your delegation will continue to follow this report most carefully.

In addition, the same Reference Committee adopted, after much discussion, "Guidelines for Hospital Teaching Programs," which are of much interest to the physicians of Georgia and these can be widely published if this House so desires. The final item of particular interest relates to relocation of the AMA Institute for Biomedical Research on, or contiguous to a University Campus, probably the University of Chicago. There are many reasons for this recommendation, and these will be discussed in detail before one of your own Reference Committees.

Lastly, Mr. Speaker, I must pay a few words of tribute for the loyalty, interest, and diligence of the other members of your Delegation, the Delegates, the Alternate Delegates, your Officers of MAG, and the Staff. The dedicated efforts of these people makes your representation in the AMA House of Delegates effective. It is significant that two members of your Delegation, John S. Atwater, M.D. and Preston D. Ellington, M.D., were honored this year by being chosen to serve on Reference Committees.

REFERENCE COMMITTEE RECOMMENDATION—Your Reference Committee approves this Report with highest commendation and notes with pleasure that the AMA Clinical Convention has been scheduled in Atlanta in 1972 through the effective efforts of the Georgia Delegation to the AMA.

HOUSE OF DELEGATES ACTION—Adopted the Reference Committee recommendation as presented.

Ninth District Vice-Councilor

ROBERT S. TETHER, M.D., *Gainesville*

REPORT OF THE APPALACHIAN MEDICAL PLANS, SECTION 212.

In Georgia no funds have been used at this time. In fact the planning is still quite vague. There are no immediate situations which will qualify for this money. In the state of Georgia, Section 214, supplementary funds in the Appalachian program have been used in Stephens, Pickens, Habersham, and Hall Counties, and in nursing facilities in Union, Fannin, and White Counties. This money is Section 214, which is supplementary funds and is not to be confused with Section 212, which is the Medical Demonstration Program.

I believe MAG should take a stand in regard to the two year nursing program and require a one year internship in a general hospital before licensure and RN degree can be obtained.

RECOMMENDATIONS

1. I would like to recommend that the MAG go on record as endorsing staff appointments to hospitals on a permanent basis, unless the physician retires or is removed from the staff of the hospital for good cause. This is in contrast to the present system used where appointments are made by hospital authorities on a year to year basis.
2. I feel MAG should recommend that hospital authorities should consist of at least ¼ to ⅓ physicians on their commissions. At the present time there is no physician representation on many of the hospital authorities and on many of the others there is only token representation. I believe this is especially important at this time with the gradual nationalization of the Medical Practice.
3. I believe it will be well for the MAG at this time to reaffirm their support of the regional mental health programs which are currently being carried out on a progressive basis in the state of Georgia.
4. I think the MAG should take a long look as to what its stand is going to be when the state funds from Medicaid run out prior to the end of the fiscal year and the Medicaid Program suddenly finds itself without any funds in order to meet its obligations. I feel this will certainly happen.

Resolution No. 11

PHYSICIAN REPRESENTATION ON HOSPITAL AUTHORITIES

ROBERT H. ANDERSON, JR., M.D.
For Hall County Medical Society

WHEREAS, many hospital authorities prohibit by charter physicians as members of the authority; and

WHEREAS, we believe the knowledge of the problems of the hospital are inherently close to the practicing physician; and

WHEREAS, this knowledge could best be utilized to the advantage of the hospital and community for improved patient care; and

WHEREAS, with increasing concern over hospital costs, we believe more active physician participation will increase cost awareness helping to stem rising costs of hospital-medical care; and

WHEREAS, we believe physicians should have a voice in the administration and policies of hospitals in which they practice.

THEREFORE BE IT RESOLVED, that at least 25% of the membership of hospital authorities be composed of local practicing physicians.

Resolution No. 13

PHYSICIAN REPRESENTATION ON HOSPITAL GOVERNING BOARDS

STUART H. PRATHER, JR., M.D.
For Richmond County Medical Society

WHEREAS, physicians licensed to practice medicine have long and rigorous training in matters of health; and

WHEREAS, physicians must place increasing dependence on hospital facilities to provide medical care for their patients; and

WHEREAS, hospital administrators and members of hospital governing boards are generally lay individuals without medical training; and

WHEREAS, hospital administrators and hospital governing boards regularly make decisions which profoundly affect community medical service and medical care.

THEREFORE BE IT RESOLVED, that the Medical Association of Georgia hereby adopt the position that physicians should be full voting members of the governing board of every hospital in Georgia approved by the Georgia State Department of Health.

BE IT FURTHER RESOLVED, that the Medical Association of Georgia shall take all practical steps to obtain new legislation which will require physicians to be full voting members of the governing board of every hospital approved by the Georgia State Department of Health.

REFERENCE COMMITTEE RECOMMENDATION—This report recommended that MAG take a stand regarding the two-year nurse program and require a year's internship in a general hospital before licensure and RN degrees are given.

Your Reference Committee recommends on this part of the report that MAG work with the nurses associations to seek methods of establishing one-year internship or equivalent experience in general hospitals with compensation for those graduating from the two-year nurse programs. The Committee was reluctant to recommend any course of action that might have the effect of reducing the number of qualified nurses. At the same time, however, it concurred in the essence of the recommendation to upgrade the practice of nursing.

This report also made four recommendations under the heading of RECOMMENDATIONS. Number 1 deals with permanent hospital staff appointments rather than annual appointments. Your Reference Committee recommends approval of this part of the report on the basis that it felt that protection of all physicians outweighed the possible disciplinary problem of those few physicians whose appointment could more easily be terminated under a one year appointment.

Recommendation number 3 dealing with MAG reaffirmation of support for the regional mental health programs currently being carried out was approved.

Recommendation number 4 addressed itself to a problem that may or may not arise. It asks that MAG take a long look at what its stand will be in the event the Medicaid Program runs out of funds. The Committee was advised that the Health Department will submit a supplemental budget request in the event this should become imminent. Accordingly the Committee feels that the Medicaid Program will probably not run out of money and that this therefore presents no major problem. It was also pointed out that these patients were adequately cared for prior to Medicaid. It would recommend to the House of Delegates that MAG watch this matter with interest.

The Committee was advised that only 6.5 per cent of the first six months' disbursements under this program went for physicians' fees and it felt this statistic to be worthy of mention to the House of Delegates. This amounted to less than $20 per claim.

Your Committee considered recommendation Number 2 together with Resolutions Number 11 and 13 as they all pertain to the same subject: namely, physician representation on hospital authorities. Following lengthy discussion, the Committee voted to recommend that recommendation Number 2 and Resolution Number 11 be disregarded in favor of an amended version of Resolution Number 13. Specifically, the Committee recommends approval of Resolution 13 when the last Resolve has been changed as follows: Delete lines 16 and 17 and insert the words, "at least one full voting member of the governing board of every hospital approved by the Georgia State Department of Health to be an active staff member of that hospital engaged in the private practice of medicine and that his appointment be made for a specified period of time and not on a permanent basis."

HOUSE OF DELEGATES ACTION—Adopted the Reference Committee recommendations as presented.

Richmond County Councilor

H. D. Pinson, M.D., *Augusta*

I would like to suggest that the House of Delegates consider the problem of payments to physicians for handling liability cases. In many instances when a case is tried in court and a lump sum payment is made to the claimant, no payment is ever made to the attending physician. I understand that the insurance companies involved cannot make payment directly to the physician unless enabling legislation is passed by our legislature.

RECOMMENDATION

I recommend that the Legislative Committee of the Medical Association of Georgia be requested to study this problem and propose appropriate legislation.

Counties and Secretaries	Members December 31, 1967 MAG	Members December 31, 1967 AMA Dues Paying Only	Members December 31, 1966 MAG	Members December 31, 1966 AMA Dues Paying Only
Richmond				
R. F. Galloway				
Augusta	272	246	265	236

REFERENCE COMMITTEE RECOMMENDATION—This report requested legislation to make possible direct payments to physicians by insurance companies in liability cases. Your Committee felt that such a stand would be inconsistent with our view that the physician should be paid his fee by the patient and should not seek payment from a third party. Accordingly, your Committee recommends that this report be disapproved.

HOUSE OF DELEGATES ACTION—Adopted the Reference Committee recommendation as presented.

Constitution and By-Laws

George H. Alexander, M.D., *Chairman*

The Committee on Constitution and By-Laws met at the Headquarters Office on October 13, 1967, to consider language to provide for a mechanism of Central Billing. This matter had been referred to Council by the 1967 House of Delegates with instructions to appoint a special committee to report back to Council with recommendations and thence to the Committee on Constitution and By-laws for preparation of the necessary amendments. Council instructed the Committee to prepare the necessary language and also language for an alternative to be used by those component societies wishing to continue under the present system.

The Committee first considered minor clarifying proposals No. 1 through 5, which are not actually related to Central Billing, but spell out the fact that Delegates and Councilors can be elected by the vote of dues paying active members only.

The Committee in its study incidentally noted a defect caused by a change in Chapter IV., Section 1., of the By-laws, which was adopted in 1965 and which provided for the Immediate Past President to serve three years as a full member of Council. It would appear that Article VI., Section 1., of the Constitution should have also been amended to provide for this. The Committee requested the MAG Attorney, Mr. John L. Moore, to prepare an amendment to Article VI., Section 1., to correct this defect. This is being introduced at this 1968 meeting of the House—to lie on the table until the 1969 meeting, for action at that time by the House.

All the above proposals will follow at the conclusion of this report with the Committee recommendations on each.

The Committee again met on February 9, 1968, at MAG Headquarters to consider three problems referred to the Committee by the Executive Committee. The Committee considered these changes and requested Mr. Moore, MAG Attorney, to prepare the necessary language. The reasons for these changes are given along with the proposed wording for each.

1. Amend Chapter I, Section 1, of the By-laws by deleting the period at the end of such Section 1, and by adding the following words to such Section 1:

"and upon paying dues to this Association as hereinafter provided."

2. Amend Chapter I, Section 2, of the By-laws by adding the words "who has paid the annual dues" between the words "and" and "of" in the fourth line of said Section 2.

3. Amend Chapter III, Section 2, of the By-laws by adding the words "to the Association" after the word "paid" in the fifth line of said Section 2.

4. Amend Chapter IV, Section 1, of the By-laws as follows:

(a) In the second paragraph, third line, after the word "members," add the parenthetical clause "(who are not in arrears in the payment of dues to the Association)."

(b) Add the same parenthetical clause at the end of the third line of the fourth paragraph after the word "members." Add the word "active" before the word "members" in the same third line of the fourth paragraph.

(c) Thereafter, each time the words "50 members" appear in the present text of the By-laws, add the word "such" between those words so that the phrase will read "50 such members." These references are in the fifth paragraph, third line; sixth paragraph, third and fourth lines; and seventh paragraph, third and fourth lines.

5. Amend Chapter VI, Section 4, Paragraph (B), second paragraph, by adding the words "Association's members of the" between the words "the" and "component" in line 2 of the second paragraph of such Section 4(B).

RECOMMENDATION

For adoption for the foregoing proposals No. 1 through 5.

Proposal No. 6(A)—Amendment necessary to provide for Central Billing.

6(A). Amend Chapter VIII, Section 3, of the By-laws by deleting said Section 3(A) in its entirety and by inserting in lieu thereof a new Section 3(A) to read as follows:

"SECTION 3. DUES AND ASSESSMENTS. (A) The annual dues and assessments shall be determined by the House of Delegates upon recommendation of the Council and shall be levied per capita on the active members of the Association. They shall be payable on or before January 1st of the year for which they are levied in accordance with the following procedures. Before October 1st of a particular year the Secretary of a component county society shall certify to the Secretary of the Association the names of members of the society, their correct mailing addresses, and the amount of dues and assessments for the next calendar year to be levied on its members pursuant to the Constitution and By-laws of the component county society. The Secretary of the Association shall bill such members for dues and assessments due the Association, the American Medical Association, and the particular component county society and collect all such dues and assessments. Within 60 days of receipt of such dues, the Secretary of the Association shall remit to the Secretary of the particular component county society all component county society dues and assessments collected by such date from its members. The Secretary of the Association shall remit to the American Medical Association all dues and assessments thus collected for it. Any member whose dues and assessments to the Association have not been paid for the current year on or before April 1st shall stand suspended until his dues and assessments for the current year have been paid.

An active member who failed to pay dues for one or more years shall be eligible for reinstatement upon payment of dues for the current year plus one year's dues in arrears subject to reapplication and approval of his county society."

Proposal No. 6(B)— Alternative to provide optional method.

"SECTION 3. DUES AND ASSESSMENTS. (A) The annual dues and assessments shall be determined by the House of Delegates upon recommendation of the Council and shall be levied per capita on the active members of the Association. They shall be payable on or before January 1st of the year for which they are levied in accordance with the following procedures:

(1) All active members of the Association who are also members of component county societies other than those described in subsection (2) hereof shall pay such dues and assessments in accordance with the following procedure. Before October 1st of a particular year the Secretary of a component county society shall certify to the Secretary of the Association the names of members of the society, their correct mailing addresses, and the amount of dues and assessments for the next calendar year to be levied on its members pursuant to the Constitution and By-laws of the component county society. The Secretary of the Association shall bill such members for dues and assessments due the Association, the American Medical Association, and the particular component county society and collect all such dues and assessments. Within 60 days of receipt of such dues, the Secretary of the Association shall remit to the Secretary of the particular component county society all component county society dues and assessments collected by such date from its members. The Secretary of the Association shall remit to the American Medical Association all dues and assessments thus collected for it. Any member whose dues and assessments to the Association have not been paid for the current year on or before April 1st shall stand suspended until his dues and assessments for the current year have been paid.

(2) All active members of the Association who are also members of a component county society which, through its appropriate officers, has certified to the Secretary of the Association before October 1st of a particular year with respect to the coming calendar year that the particular society elects to be governed by this subsection (2), the following procedure shall apply. The Secretary of such component county society shall cause to be collected and shall forward to the office of the Association before January 1st the dues and assessments for its members, together with such data as shall be required for a record of its officers and membership. Any member whose name has not been reported for enrollment and whose dues for the current year have not been remitted to the headquarters office of the Association on or before April 1st shall stand suspended until his name is properly reported and his dues for the current year properly remitted. At no time and under no circumstances shall a member make payment of dues or assessments directly to the headquarters office of the Association. Neither shall the headquarters office of the Association receive payments of dues or assessments from anyone except the Secretary of such component county society or his representative.

An active member who fails to pay dues for one or more years shall be eligible for reinstatement upon

payment of dues for the current year plus one year's dues in arrears subject to reapplication and approval of his county society."

The Constitution and By-laws Committee recommends either the adoption of No. 6(A) or the defeat of the entire proposal. The adoption of *6(B) is not recommended.*

Proposal No. 7—To Amend Article VI., Section 1., of the Constitution to correct defect caused by amending Chapter IV., Section 1., of the By-laws in 1965.

BE IT RESOLVED, that Article VI, Section 1, of the Constitution of the Medical Association of Georgia be amended by inserting the words "the two preceding Immediate Past Presidents," after the phrase "the Immediate Past President" in said Section 1, so that said Section 1 as thus amended shall read as follows:

"ARTICLE VI.

Council

Section 1. COMPOSITION. Council is composed of the President, the President-Elect, the Immediate Past President, the two preceding Immediate Past Presidents, two Vice-Presidents, Secretary, Speaker of the House of Delegates and Councilors as provided for in the By-laws. Delegates to the AMA, the Treasurer, Editor of the *Journal* and the Executive Secretary shall be ex-officio members of Council without the right to vote. Vice-Councilors shall be ex-officio members except in the absence of their respective Councilors as provided for in the By-laws. The Vice-Speaker shall be an ex-officio member except in the absence of the Speaker as provided for in the By-laws."

This proposal will have to lie on the table until the 1969 meeting for action at that time by the House of Delegates.

Proposal No. 8—Concerning Invitations for Annual Session Sites.

Chapter II, Section 6: *Change Suggested.*—Change the references to two years in advance of Annual Session for invitations and decisions as to Annual Session and substitute a sufficient number of years in advance to allow for hotel and other reservations.

New Text.—Section 6:

"SECTION 6. Invitations from component county medical societies to the Association for its Annual Session shall be forwarded to Council a sufficient number of years, as prescribed by Council, in advance of the particular Annual Session, to allow for the making of hotel and other reservations. Council shall make recommendations to the House of Delegates and the House of Delegates shall decide as to the site of the meeting of the particular Annual Session a sufficient number of years in advance, as prescribed by Council, to allow for the making of hotel and other reservations."

Reason for Change. It becomes more and more necessary to make reservations longer in advance in order to be sure of the availability of space. The AMA now makes its decisions more than five years in advance of particular meetings.

RECOMMENDATION

For Adoption.

Proposal No. 9—Concerning component societies with less than five members and revocation of charter.

Chapter VII, Section 2: *Change Suggested.*—Add a sentence automatically revoking the Charter of any county society which should not maintain the required minimum number of members.

New Text.—Section 2:

"SECTION 2. CHARTER. Council shall provide and issue charters to county medical societies organized to conform to this Constitution and By-laws Such charters shall be signed by the President and the Secretary. The House of Delegates shall have authority to revoke the charter of any component county society whose actions are in conflict with the letter or spirit of this Constitution and By-laws. Only one component county society shall be chartered in each county. The charter of any component county society shall stand automatically revoked as of February 1 following twelve consecutive full calendar months when the total dues forwarded by the Secretary of the particular component county medical society to the Association shall constitute the dues of less than five active members. Any society whose charter is thus automatically revoked may apply for a new charter by following the procedures established in Section 1 of this Chapter VII."

Reason for Change.—While Section 1 of Chapter VII seems to require a component county medical society to have five or more active members, no procedure has been previously provided in the By-laws for removing the Charters of societies whose membership falls below five. There are adequate provisions in Section 8 of Chapter VII for combining societies in sparsely settled sections.

RECOMMENDATION

For adoption.

Proposal No. 10—To change date of election and reporting to the Association the election of officers and delegates from January 1st to February 1st.

Chapter VII, Sections 6, 7 and 9: *Suggested Change.*—To change the date for election and reporting to the Association of the election of officers and Delegates from January 1 to February 1.

New Text.—Section 6:

"SECTION 6. DUTIES. Each component county society shall meet the following five minimum standards: Each society shall (1) meet a minimum of four times a year, elect officers and delegates annually at a meeting before February 1st, and report these officers to the headquarters office before February 1st; (2) maintain an up-to-date constitution and by-laws in conformity with the Constitution and By-laws of the Medical Association of Georgia and shall transmit a copy of its constitution and by-laws to the headquarters office for record; (3) maintain a Board of Censors and/or a Mediation Committee; (4) maintain minutes of each meeting in a permanent record book that will be available at all times; and (5) maintain scheduled programs at its minimum four meetings annually."

Section 7:

"SECTION 7. DELEGATES. Each component county society shall elect prior to February 1st delegates and alternates to the House of Delegates in

accordance with these By-laws. The Secretary of each component society shall send a list of such delegates to the Secretary of the Association before February 1st. In the absence of, or the disability or disqualification of a delegate, the vacancy may be filled by the President of the society from other members of the same component society, provided such vacancy is filled prior to the first session of the House of Delegates."

Section 9:

"SECTION 9. ANNUAL MEETING. Each component county society shall designate a meeting held prior to February 1st as its annual meeting at which time officers and delegates for the next year shall be elected and their names forwarded before February 1st to the Secretary of the Association."

Reason for Change.—Section 2 of Chapter III of the By-laws provides the number of Delegates each county society is entitled to elect, such number depending upon the number of members of the society whose dues have been paid through December 31st. However, the Provisions of Chapter VII, Sections 6, 7 and 9 require the election of Delegates prior to January 1st. The actual procedure followed is that the Medical Association of Georgia notifies the county society of the number of Delegates to which they are entitled around January 5 of each year, based on its roster of members as of January 1. It is, therefore, necessary to make the date later by which county societies must elect the Delegates and notify the Association.

RECOMMENDATION

For adoption.

You will note the recommendations of the Committee. These recommendations are made in compliance with Section 6, Chapter IX., of the By-laws. They are made realizing that they go through Council and thence to the House of Delegates. Council action may or may not be the same on all points as the Committee's.

COUNCIL ACTION—*Council recommends adoption of all recommended amendments to the Constitution and Bylaws as proposed by the Constitution and Bylaws Committee.*

Supplemental Report of Council No. 3

CENTRAL BILLING

F. G. Eldridge, M.D., *Chairman*

Pursuant to the adoption of Resolution 6 by the 1967 House of Delegates, a study committee to consider and determine the feasibility of instituting a central billing system for the Medical Association of Georgia was appointed.

Central billing as contemplated by Resolution 6 would take the place of the dues collection system now used. The present system is such that bill statements are printed by the Headquarters Office, mailed in bulk to County Medical Society Secretaries who in turn must enter the amount of their particular County Society and where applicable, District Society dues on said statements and mail them out to the members of their respective Societies. Such statements are then returned with dues check to the County Secretary who determines from the amount of the check with which medical organizations the member has chosen to affiliate.

By contrast, and for the sake of your comparison, under central billing statements would be prepared by the Headquarters Office and mailed directly to each physician reported to be a member of any component County Medical Society. The individual physician would then return his dues money direct to MAG and MAG would rebate to the County Medical Society their portion of the dues collected. MAG dues would be retained at the Headquarters Office and AMA dues forwarded.

The Central Billing Study Committee after a thorough and exhaustive review of the present billing system, and following numerous conferences with representatives of computer service companies, recommended to Council that a system of centralized-computerized billing for MAG dues be installed as soon as feasible.

Council discussion of this report led to an additional recommendation that the Constitution and By-laws Committee draft a By-laws amendment which would permit central billing for all component County Medical Societies and also draft an alternate provision that would permit central billing on a county option basis.

The Constitution and By-laws Committee has performed this task as their report will indicate. The matter of central billing was presented to Council on three separate occasions, September and December 1967, and again in March 1968. On this latter occasion, the Constitution and By-laws Committee requested Council to go on record in support of its contention that central billing should be adopted for the entire State or that it should be rejected for all. The Committee reasoned that it would not be feasible either from the standpoint of cost or administration to maintain two distinct billing systems (one, centralized by computer, and second, the present system) and hence urged the Council to support their position. It should be remembered that Council approved the idea of central billing at its meeting in September and reaffirmed its position at December Council.

At the March meeting of Council, therefore, the question was not whether Council approved or disapproved central billing. The fact that it had previously endorsed the central billing concept and permitted this endorsement to remain standing at the March meeting speaks for itself. Rather, the question addressed itself

Taking part in the panel entitled "Efficiency in Medical Practice" presented by the Medical Education Committee before the General Assembly are Amos Neil Johnson of Garland, N.C.; Krikor Soghikian of Oakland, California; and Richard Bramblett of Augusta. Moderating, at far right, is J. Rhodes Haverty.

to Council's position on the matter of adopting central billing for all component County Medical Societies, or rejecting central billing altogether.

RECOMMENDATION:

On this question, Council voted to support the concept that MAG should have only one billing system, standardized for the entire Association, rather than two distinct billing systems that would likely prove costly and administratively unfeasible. This position is in accord with the recommendation of the Committee on Constitution and By-laws.

Supplemental Report of Committee on Constitution and By-laws

CORRECTION OF COMMITTEE REPORT IN HANDBOOK

GEORGE H. ALEXANDER, M.D., *Chairman*

You will note in the Committee's report in the Delegate Handbook that proposals No. 1 through 5 are lumped together as not pertaining to "Central Billing."

Proposal No. 5 does pertain to central billing—the error having been made due to the rush to meet the deadline for the printing of the Handbook.

The recommendation should have read: For adoption of proposals No. 1 through 4.

Comment and typographical error on No. 5 follow:

In the wording of the addition in Chapter VI, Section 4, Paragraph B, second paragraph:—the third word "of" appearing between "members" and "the" should be changed to read "or."

When amended, this paragraph would read, "The Secretary shall collect the regular per capita assessment from the *Association's members or the* Component Societies and shall make all required reports to the American Medical Association." (Italic indicates new language)

It is felt that the adoption of proposal number 5 would be necessary if Central Billing or the Alternate proposal to Central Billing is approved. However, if Proposal number 6A (Central Billing for all component societies) is adopted, the addition of the words "Association Members" would be better, and in that event the words "Component Societies" should be deleted. If neither Proposal 6A or 6B (Central Billing by County Society option) is adopted, Proposal number 5 should not be approved.

REFERENCE COMMITTEE RECOMMENDATION—In considering this report, your Committee also considered Supplemental Reports 3 and 6 relating to matters in the report of the Committee on Constitution and Bylaws.

Proposals 1, 2, 3, 4, 8, 9, and 10 were approved as presented in the Handbook. Each is a technical amendment that makes no change of substance. Proposals 9 and 10, however, do merit mention. Proposal 9 provides for the revocation of charter of a County Medical Society when its membership falls below five members which is the number necessary to obtain a charter. Proposal 10 changes the dates of the election of MAG Delegates by County Medical Societies from January 1 or February 1. This will permit the MAG Headquarters Office time to advise each Society of the number of entitled Delegates and avoid an invalid election of a Delegate in the event of a reduction in membership.

Proposal 7 is a Constitutional amendment that brings the Constitution in line with an amendment to the By-laws adopted several years ago. It relates to the composition of Council and specifically to the point of Past Presidents serving on Council. As a Constitutional amendment, it cannot be voted on this year as it must "lay over on the table" a year. Accordingly, your Reference Committee notes that this proposal has been received and approves its introduction to the House.

Proposals 6(A), 6(B), and Supplemental Reports 3 and 6 all address themselves to Central Billing.

The matter of Central Billing was discussed by those appearing before the Committee and by the Committee itself in great detail. Your Committee heard many arguments both pro and con. Based on all arguments heard and on the reasoned judgment of the Committee, it is recommended that Central Billing be adopted but that neither Proposal 6(A) or 6(B) be adopted. Instead, your Committee proposes a third alternative that will permit County Medical Societies which choose to do so to collect their own dues, and permit MAG to collect the balance. Specifically, the Committee reasoned that MAG should bill for its own dues and that County Societies desiring to use MAG facilities for the collection of their dues should be permitted to do so.

To accomplish this, your Reference Committee recommends approval of Proposal 6(A) as amended by adding the language shown by italics:

Proposal No. 6(A)—Amendment necessary to provide for Central Billing.

6(A). Amend Chapter VIII, Section 3, of the By-laws by deleting said Section 3(A) in its entirety and by inserting in lieu thereof a new Section 3(A) to read as follows.

"Section 3. DUES AND ASSESSMENTS. (A) The annual dues and assessments shall be determined by the House of Delegates upon recommendation of the Council and shall be levied per capita on the active members of the Association. They shall be payable on or before January 1st of the year for which they are levied in accordance with the following procedures. Before October 1st of a particular year the Secretary of a component county society shall certify to the Secretary of the Association the names of members of the society *who are or wish to be members of this Association and information as to their status with the American Medical Association*, their correct mailing addresses, and the amount of dues and assessments for the next calendar year to be levied on its members pursuant to the Constitution and Bylaws of the component county society *if the county society elects to have this Association collect dues for the particular component county medical society.* The Secretary of the Association shall bill such members for dues and assessments due the Association, the American Association, and the particular component county society *(in cases where the component county medical society has elected for its dues to be collected by the Association)* and collect all such dues and assessments. Within 60 days of receipt of such dues, the Secretary of the Association shall remit to the Secretary of the particular component county society all component county society dues and as-

sessments collected by such date from its members. The Secretary of the Association shall remit to the American Medical Association all dues and assessments thus collected for it. Any member whose dues and assessments to the Association have not been paid for the current year on or before April 1st shall stand suspended until his dues and assessments for the current year have been paid.

An active member who failed to pay dues for one or more years shall be eligible for reinstatement upon payment of dues for the current year plus one year's dues in arrears subject to reapplication and approval of his county society."

The Committee recommends disapproval of Proposals 5 and 6(B) of the report of the Committee on Constitution and By-laws.

HOUSE OF DELEGATES ACTION—The House adopted the Reference Committee recommendations on proposals 1, 2, 3, 4, 8, 9 and 10 as presented. The House also approved the Reference Committee recommendation on proposal 7, a Constitutional amendment and received it as being introduced to the House. With reference to proposals 5, 6(A), and 6(B), Speaker Rogers recognized Luther Vinton, Decatur, who recommended disapproval of the idea of billing from a central office until such time when computerization became feasible. Speaker Rogers then recognized Linton Bishop, Atlanta, who recommended the adoption of a voluntary system allowing county option, and offered a substitute motion to disapprove the Reference Committee recommendation by adopting proposals 5 and 6(B). By a show of hands, the substitute motion was adopted by a vote of 51 for and 46 against.

Legislation

J. Frank Walker, M.D., *Chairman*
National Legislation
Harrison L. Rogers, Jr., M.D., *Chairman*
State Legislation

The early deadline for receipt of this report (in order that it may be printed in the Handbook) will necessitate a Supplemental Report by the Committee to detail the activities of the Association during the 1968 session of the Georgia General Assembly. This report, therefore, deals only with those Committee activities that occurred during the interim period between the close of the 1967 MAG Annual Session and February 15, 1968.

NATIONAL LEGISLATIVE ACTIVITY

There were numerous bills of interest and concern to the medical profession offered in the Congress during 1967. None caused more concern nor drew greater attention than the "Social Security Amendments of 1967," more commonly known as the amendments to Medicare and Medicaid.

In addition to the numerous contacts made between your Committee and members of the Georgia Congressional Delegation to urge their support of the MAG views regarding this bill (H.R. 12080), the Committee filed a statement with the Senate Finance Committee in support of these views. Of particular concern were two matters relating to billing pursuant to Titles 18 and 19, Medicare and Medicaid. In this statement, MAG supported the view that payment for physician services under Part B (Medicare) should be possible on the basis of an itemized (but unpaid) statement, rather than holding to the rigid view (enacted in the original bill) that such payment would be authorized only on the basis of a receipted bill.

Secondly, our statement supported the view that direct billing under Title 19 (Medicaid) should be authorized. Both of these views were adopted by the Congress and signed into law. However, with respect to direct billing under Title 19, this is left to the option of the States.

Also of great concern was the provision written into the bill by the Senate to include chiropractors as providers of service. Quoting in part, the statement read, ". . . specifically we are concerned over the possible expansion of the program to include the services of chiropractic. In the view of the medical profession chiropractic represents cultism in one of its most flagrant forms. The dogma of its irrational tenets actually resist scientific advances in the diagnosis and treatment of human disease. As a healing art, it constitutes a hazard to good health care in the United States and should be resisted on the basis of its own lack of merit." Chiropractic was ultimately eliminated from the bill, as were the services of optometrists and clinical psychologists.

Another bill of significant importance to medicine was the so-called Partnership For Health amendments (H.R. 6418). One of the most controversial aspects of this bill was the provision relating to Federal licensure of clinical laboratories.

As the bill ultimately emerged into law, the following interstate clinical laboratories were omitted from the licensure requirement: Those laboratories accredited by the Joint Commission on the Accreditation of Hospitals, the College of Pathologists, and the American Osteopathic Association. Also, clinical laboratories in those states that adopt regulations equal to or more stringent than those adopted by the Secretary of HEW are exempt.

Laboratories operated as an adjunct to a physician's private practice would not be subject to the provisions of the Act.

A matter that will hopefully be resolved by the Congress this year relates to a ruling by the Internal Revenue Service proposing to tax the income derived by advertising in journals (such as *JMAG* and *JAMA*, etc.) as unrelated to the main purposes of the Association or to the basis on which non-tax status was originally granted. Several bills are pending in the House Ways and Means Committee as of the writing of this report and MAG is cooperating with the AMA to press for enactment of any one of these bills in the interest of overturning this IRS ruling.

MAG and your Legislative Committee continued to strengthen its liaison with members of the Georgia Congressional Delegation through the annual MAG Washington Luncheon. The 1967 Luncheon held in late May was a successful trip and contributed much to a better understanding between Georgia Members of Congress and their physician constituents. The 1968 Luncheon has been scheduled to coincide with the AMPAC Workshop in Washington with the view toward exposing those attending the Luncheon meeting with the mechanics of the election process.

STATE LEGISLATIVE ACTIVITY

As of the time of filing this report, the Georgia General Assembly has two weeks remaining in its regular

1968 Session. The previously mentioned supplemental report dealing with events of this Session will be filed with the House of Delegates upon adjournment of the Legislature. Certain activities of the Committee merit mention now, however.

An exhaustive effort was made during the fall months (1967) to acquaint MAG members and members of the General Assembly with the MAG position regarding podiatry and optometry. An elaborate plan to organize "expert" speakers on these subjects and have them address county medical societies in the presence of local members of the Legislature was formulated. As a result, MAG was able to spread the word on these two important subjects to many parts of the State and to expose members of the General Assembly to our views in places and under circumstances never tried before.

Your Committee also made special efforts to better establish liaison on health and medical legislation with members of allied organizations, the Department of Public Health and the Board of Medical Examiners.

In early January, the Committee, in cooperation with the MAG Committees on Public Service and Traffic Safety and the *Journal of MAG,* distributed to all members of the Georgia General Assembly, a special issue of *JMAG* dealing in its entirety with traffic safety and the need to enact a legislative package of bills designed to curb traffic accidents.

Your Committee wishes to pay special tribute to four physicians who continue to serve the cause of good medical legislation through continuous service in the Georgia General Assembly. Your Committee becomes increasingly aware of the fact that such service can only be given at the price of a great personal sacrifice. These physicians are: Carl P. Savage, Montezuma, Frank P. Holder, Eastman, C. C. Moreland, Monroe, and A. S. Johnson, Elberton.

Your National and State Chairmen offer daily thanks for the services of Jim Moffett, whose legislative stature grows and grows.

Supplemental Report of the Committee on Legislation No. 4

1968 SESSION OF GEORGIA GENERAL ASSEMBLY

J. Frank Walker, M.D.
Chairman (National Legislation)
Harrison L. Rogers, Jr., M.D.
Chairman (State Legislation)

The 1968 session of the Georgia General Assembly was an extremely busy one for your Committee on State Legislation. There were more than 50 bills of interest to the medical profession, some of which were carried over from the previous session in 1967. The most distinguishing difference between the 1968 session and those in the past is the apparent increase in interest in medical legislation on the part of the members of the General Assembly.

The avalanche of Federal health programs enacted by the Congress in recent years has seemingly sparked concern in State legislatures in many areas previously felt not to be subject to extensive review. The following list of bills and actions taken on them is an accounting of the more important legislative matters considered by the 1968 General Assembly:

ABORTION: H.B. 281, introduced at the 1967 session of the General Assembly and passed by the House that year, was held over to the 1968 session in the Senate Judiciary Committee for an exhaustive review. This bill has been described as a "liberalization" of Georgia's abortion statutes. The fact of the matter is, however, that under H.B. 281 it will be more difficult to obtain a legal therapeutic abortion in Georgia than was possible under the previous law.

The previous statute governing abortions in Georgia was enacted in 1876 and unchanged since that time. It provided (Ga. Code Chapter 26-1101):

> "Any person who shall administer to any woman, pregnant with a child, any medicine, drug, or substance whatever, or shall use or employ any instrument or other means, with intent thereby to destroy such child, unless the same shall be necessary to preserve the life of such mother, or shall be advised by two physicians to be necessary for such purpose, shall, in case of the death of child or mother be thereby produced, be guilty of an assault with intent to murder."

The enactment of House Bill 281 (as amended) as is shown by a comparison with the 1876 statute, actually makes obtaining an abortion more restrictive with respect to criteria that must be met. At the same time, however, it considerably extends the reasons for which an abortion may be sought and performed.

This bill (H.B. 281) was permitted to become law without the signature of the Governor. He, of course, could have exercised his right of veto but declined to do so and the net effect is the same as if he had signed the bill into law.

This bill provides that a therapeutic abortion is legal in Georgia when the following conditions are met:

(1) The woman must be a bona fide resident of Georgia;
(2) The procedure must be performed in a hospital approved by the Joint Commission on the Accreditation of Hospitals;
(3) Three physicians must concur in the medical necessity for such procedure based on their separate examination of the woman. These concurrences must be reduced to writing, kept on file at the hospital, and at all reasonable times be available to the Solicitor General of the judicial circuit;
(4) The procedure must be approved in advance by a committee of the medical staff of the hospital created to approve (or reject) abortions.

The bill also provides for certain relatives of the woman, or the Solicitor on his own behalf to request a declaratory judgment from the bench on the question of whether or not the legal and constitutional rights of the fetus are being violated. If the court rules that they are, then the abortion could not be performed.

Assuming each of these conditions is met, a legal therapeutic abortion may be performed in Georgia for the following reasons:

(1) A continuation of the pregnancy would endanger the life or would seriously and permanently injure the health of the woman;
(2) The fetus would very likely be born with a grave, permanent and irremediable mental or physical defect;
(3) The pregnancy resulted from forcible or statutory rape.

IMMUNIZATIONS: Prior to the enactment of this bill there was no uniformity as to the immunizations which must be obtained as a condition to entering the public schools of this State. Such matters were left entirely in the hands of local school boards, which meant that adjoining counties, subject to the jurisdiction of two separate school boards, may have imposed different immunization requirements.

House debate on this bill produced evidence to the fact that five counties in Georgia did not require smallpox immunization.

Testimony given before a Senate committee by a group of Georgia chiropractors requested that their children be exempted from this Act on the basis that it violated the beliefs of their "profession." This was ultimately rejected on the floor of the Senate. The bill as ultimately passed by both chambers stipulated that no child could be admitted to public school until immunized against certain contagious diseases. The State Board of Health was authorized to determine which immunizations would be required and to transmit this information to local Boards of Health who in turn must see that these are implemented.

This Act would not apply to religious objectors, or to children with a physical condition which may contraindicate vaccination.

This bill was also permitted to become law without the signature of the Governor.

IMPLIED WARRANTIES ON BLOOD: This bill was felt to be necessary by reason of a court decision which held that transfused blood constituted a sale and therefore was subject to the implied warranties of merchantability. The medical profession had, of course, always held this to be a medical service and not a sale. This bill, H.B. 1292, introduced by Representative Carl Savage, M.D., provides that the implied warranties of merchantability and fitness shall not apply to the procurement, processing, storage, distribution or use of whole human blood, blood plasma, blood derivatives or other human tissue or organs for the purpose of injecting, transfusing or transplanting into the human body. *This bill was enacted.*

WORKMAN'S COMPENSATION: Legislation increasing the maximum medical expenses from $2,500 to $5,000 under Workman's Compensation *was enacted.* Benefits generally under Workman's Compensation were increased by the passage of this bill. This legislation has been a long time coming, as industry and labor were never able to agree on the terms of an acceptable bill.

CONFIDENTIAL COMMUNICATIONS: A bill which had MAG endorsement (although not sponsored by MAG) but *failed of enactment* would have extended the privilege of confidential communications to include those communications between physician and patient. This privilege is now provided for by statute for psychiatrists, but does not include any other medical practitioner.

TRAFFIC SAFETY: Several bills relating to traffic safety which MAG had previously endorsed were enacted. These were: S.B. 120, Implied Consent; Pursuant to this bill, a driver is presumed to have given his consent to be tested for the level of alcohol in his blood to determine if he is, in fact, intoxicated. Such test would be ordered by a law enforcement officer when suspicion of driving-under-the-influence is present. Failure to submit to the test would result in revocation of drivers permit.

H.B. 881, Point System; Traffic violations are assigned point value and upon the accumulation of a certain point total a drivers permit is suspended or revoked.

H.B. 843, Radar; Authorizes use of speed timing devices by municipalities with safeguards written into the law to prevent "speed trap" abuse.

H.B. 839, Reflective License Plates; Authorizes Revenue Director to design and sell automobile license plates that reflect light in an effort to reduce rear end collisions during night driving.

Each of these Traffic Safety bills was enacted.

PSYCHODRAMA: S.B. 174, a bill to license people "qualified in the use of psychodrama" *was not enacted.* This bill would have authorized non-physicians to engage in the practice of treating mentally disturbed people by showing them how to act out their frustrations.

FREEDOM OF CHOICE OF M.D. OR THERAPIST: This bill, H.B. 1106, would have provided by statute for the complete freedom of choice of physician or therapist under any and all accident and sickness insurance contracts as well as under Workman's Compensation. Freedom of choice within the meaning of this bill would have included chiropractors, optometrists, naturopaths, etc. *This bill was not enacted.*

BOARD OF HEALTH: A bill to change the composition of the Board of Health by adding a hospital administrator was introduced but failed of enactment.

FLUORIDATION: This bill would have authorized the State Health Department to fluoridate local water systems. It was killed in the House Committee on Hygiene and Sanitation.

CLINICAL LABORATORIES: There were three bills on this matter: H.B. 775 sponsored by the pathologists; H.B. 1024 and H.B. 1026 sponsored by certain clinical laboratory technologists were all held out of consideration and will be taken under close examination by an interim study committee this summer. H.B. 775 provided for the licensing of clinical laboratories and would require that an M.D. assume responsibility for work done by the laboratory. H.B. 1024 provided for the licensing of laboratory personnel, and H.B. 1026 provided for licensing of laboratories and personnel.

MAG supported H.B. 775 but opposed the other two.

The foregoing list of bills by no means covers all the legislation which MAG followed closely throughout the two year life of the recently adjourned legislative term. In all there were over 50 bills of interest to MAG. All legislation not enacted prior to adjournment on March 8 died with this session of the General Assembly. No bills will be carried over until next year and must of necessity be introduced again and run the full course of the General Assembly before they can become law.

REFERENCE COMMITTEE RECOMMENDATION—Your Committee considered the Report of the Committee on Legislation and Supplemental Report 4 of the Legislative Committee together. The Committee approved this report with highest commendation and noted that no specific recommendations were made. Mention of House Bill 775 relating to licensing of

clinical laboratories will be commented upon at a later reference in the report of this Committee.

HOUSE OF DELEGATES ACTION—Adopted the Reference Committee recommendation as presented.

Occupational Health

T. A. PETERSON, M.D., *Chairman*

The 1967 annual AMA Congress on Occupational Health was held in Atlanta at the Regency House and was considered quite a success. It was the first time this meeting had been held in Georgia in many, many years.

Your Chairman has dealt with many requests from Physicians throughout the state and very definite efforts have been made to increase the total Workmen's Compensation payments.

REFERENCE COMMITTEE RECOMMENDATION—This report was approved.

HOUSE OF DELEGATES ACTION—Adopted the Reference Committee recommendation as presented.

School Child Health

FRED L. ALLMAN, JR., M.D., *Chairman*

The functions of the School Child Health Committee of the Medical Association of Georgia during the past year have been to stimulate cooperation by individual physicians in the School Child Health Program; to keep the profession informed on School Health Problems; to encourage sanction by the medical profession of a sound school health program and to report to the profession on progress. Our committee has improved its relations within the community by developing reciprocal relations with the Dental Society, School System, Health Department, Parent Groups, Georgia High School Association and other appropriate organizations.

Specifically, the Committee has accomplished the following:

I. FOLLOW-UP OF EXISTING PROJECTS

a. Smoking and Health: Teacher Resource Kits which were placed in the schools last year in cooperation with the State Department of Education, The Georgia Heart Association, The Georgia Tuberculosis Association, The Georgia Cancer Society and the State Health Department have been well accepted in many schools throughout Georgia and the model has been utilized in other states. Evaluation of the program continues.

b. The Medical Association of Georgia through the Committee on The Medical Aspects of Sports of the School Child Health Committee again sponsored a postgraduate course on The Medical Aspects of Sports.

Members of the Committee, other members of the Medical Association of Georgia and Dr. O. B. Murphy was the Head Athletic Trainer for the Detroit Lions of of Lexington, Kentucky and Mr. Millard Kelly of Detroit, Michigan were speakers. Dr. Murphy is Chairman of the School Child Health Committee of The Medical Association of Kentucky and is also past chairman of The American Medical Association Committee on The Medical Aspects of Sports. Mr. Kelly for many years The National Professional Football League.

A highlight of the meeting was a luncheon which was cosponsored by the Health Department under the supervision of Mrs. Mary Helen Goodloe and the Florida Citrus Commission. Over 100 coaches and physicians attended the luncheon and heard a fine presentation on "Nutrition for the Athlete."

c. The Committee recommended to the Georgia High School Association, and Mr. Sam Burke, that the American Medical Association Guide for Medical Evaluation of candidates for school sports be made available to all participants of athletic teams in schools throughout our State, and the forms contained therein should be the minimum information furnished for each candidate for an athletic team.

d. The Committee submitted an article on "Heat Stress and the Athlete" which appropriately appeared in the *Journal of the Medical Association of Georgia* last July.

e. Immunization schedules were mailed out to all physicians throughout the State. These schedules brought the physician up to date on changes which have recently taken place, including recommendations regarding measles immunization.

f. The Committee has continued to cooperate with The Georgia Interagency Council on School Child Health and it is hoped that the Medical Association of Georgia will see fit to continue to have a representative of our Committee on this Council.

g. Representatives of this committee have continued to serve on the planning committee for the "Youth Conference on Smoking and Health" and on The Advisory Committee of the Georgia Teen-Age Nutrition Program. Our Committee was also represented at the World Conference on Smoking and Health and at the Eleventh National Conference on Physicians and Schools, both worthwhile activities.

II. FUTURE PROJECTS

a. The Medical Aspects of Sports Conference will be held again this year. All physicians and coaches are urged to attend this meeting which will be held early in August.

b. The Committee has continued to investigate forms for the classification of students for physical education. It is hoped that soon a form will be available to all schools throughout the state so that students might be classified for physical education listing any limitations which they might have and outlining briefly those activities which would not be harmful.

c. Guidelines for pre-adolescent participation in sports are still in preparation. It is hoped that during the present year these guidelines will be available for distribution.

The Committee would like to urge each member of the Medical Association of Georgia to help develop the integrated relationship of health and education. There can be no question that one needs to be educated in order to develop and protect one's health, and one needs abundant health to make full use of one's education. It is a reciprocal and actual relationship that deserves the attention of every physician in Georgia.

REFERENCE COMMITTEE RECOMMENDATION—This report which outlined past activities and future projects of the School Child Health Committee was approved with highest commendation for the fine work being done by this Committee.

HOUSE OF DELEGATES ACTION—Adopted the Reference Committee recommendation as presented.

Separate Billing

DONALD R. ROONEY, M.D., *Chairman*

During the past year, the committee chairman has corresponded with all committee members outlining functions of this committee and asking for suggestions. Reprints were sent to all committee members showing steps necessary for "captive specialists" to initiate independent practice with separate billing, and other reprints outlined reasons why these captive specialists should try to initiate independent practice. Similar material was sent to members of the Fulton County Medical Society working on this problem.

Radiologists' groups in two additional large hospitals in Augusta and Atlanta converted to independent practice with separate billing during the past year.

The committee has corresponded frequently with government agencies and private insurance carriers providing medical insurance to help solve problems with independent billing by hospital based medical specialists.

Independent practice with separate billing has been practiced by a large number of hospital based medical specialists in Georgia, and throughout the country, for a long enough period of time to demonstrate that separate billing is a successful and effective procedure. Private and governmental insurance programs are now reimbursing the professional fees of these specialists in the same manner as other physician fees.

RECOMMENDATIONS

1. Suggest that MAG provide a speaker for their next Annual Session dealing with effective ways for the "captive" hospital based medical specialists to successfully initiate independent practice with separate billing.
2. Continue to supply help and information to physicians employed by hospitals who wish to establish independent practice with separate billing.
3. Suggest that the Medical Association of Georgia consider reaffirming AMA policy which states: "Hospital insurance should not include the sale of medical services." (Judicial Council Opinions and Reports, 1964, Section 6, No. 21).

Resolution No. 8

HOSPITAL INSURANCE SHOULD NOT INCLUDE THE SALE OF MEDICAL SERVICES

DONALD R. ROONEY, M.D.,
of Cobb County Medical Society

WHEREAS, payment of fees for physicians' professional services by Blue Cross and similar hospital insurance plans incorrectly classifies the practice of medicine as a hospital service, and

WHEREAS, the practice of medicine can be performed legally in Georgia only by a licensed physician and not by a hospital, and

WHEREAS, the sale of physicians' services in hospital insurance policies is contrary to long established policy of the American Medical Association, and

WHEREAS, the American Medical Association has urged all constituent associations to take such action as may be deemed necessary to effect the transfer of professional services from Blue Cross plans and all other hospitalization plans to Blue Shield or that section of insurance plans providing for professional services, wherever such situations exist, and

WHEREAS, the continued sale of physicians' services, including but not limited to the services of pathologists and radiologists as hospital services, causes patients, insurance carriers and governmental agencies to no longer regard these medical services as the practice of medicine; and

WHEREAS, the insurance mechanism for payment of physicians' fees is already established in Blue Shield plans, similar physician medical insurance plans, and in the physician portion of various government health programs.

NOW THEREFORE BE IT RESOLVED, that Medical Association of Georgia policy state that hospital insurance should not include the sale of physicians' professional services.

REFERENCE COMMITTEE RECOMMENDATION—This report was considered together with Resolution No. 8. Your Committee recommends approval of the three recommendations in the Report and also Resolution No. 8 (which is substantially the same as Recommendation Number 3 of the Report). Resolution No. 8 would declare as MAG policy "that hospital insurance should not include the sale of physicians' professional services."

HOUSE OF DELEGATES ACTION—Adopted the Reference Committee recommendation as presented.

Special Activities

WILLIAM C. COLES, M.D., *Chairman*

The special activities committee functions only on requests, and no request was received for the functioning of this committee in the past year.

REFERENCE COMMITTEE RECOMMENDATION—This report was received for information.

HOUSE OF DELEGATES ACTION—Adopted the Reference Committee recommendation as presented.

Resolution No. 2

RESOLUTION ON GaMPAC

STUART PRATHER, JR., M.D.
For Richmond County Medical Society

WHEREAS, The American Medical Association has previously endorsed the establishment of an independent, voluntary, non-profit and bipartisan organization to promote education and political action known as the American Medical Political Action Committee, AMPAC; and

WHEREAS, An independent voluntary, non-profit and bipartisan organization to promote education and political action has been established in Georgia known as the Georgia Medical Political Action Committee, GaMPAC; and

WHEREAS, It is essential to continue to promote education and political action by supporting GaMPAC membership programs and by participation in political education projects; therefore be it

RESOLVED, That this House of Delegates reaffirms its support of GaMPAC and commends its leadership.

REFERENCE COMMITTEE RECOMMENDATION—This Resolution, reaffirming House of Delegates' support of GaMPAC and commending its leadership, was approved. The Committee wishes to strongly urge all MAG members to become politically active and join the PAC movement.

HOUSE OF DELEGATES ACTION—Adopted the Reference Committee recommendation as presented.

Resolution No. 3

HOSPITAL PRIVILEGES FOR GENERAL PRACTITIONERS

JOHN B. O'NEAL, M.D.
For Elbert-Franklin-Hart Medical Society

WHEREAS, there is recognition on the part of the American people that there is a right to, and the need for, medical and hospital care; and this growing recognition of a right to medical and hospital care is reinforced by the use of public funds in the training of doctors and in the building and supplying of hospitals; and

WHEREAS, the American people believe that the effective way of securing medical and hospital care and treatment is through a family physician of their own choice, a physician whose presence, support and medical knowledge should be available at all times, together with the professional skill and advice of trained specialists and consultants, and

WHEREAS, the family physician cannot fully and adequately serve his patients with first-class medicine, cannot properly diagnose and treat the illnesses of his patients unless he has staff privileges in a full-facility hospital, that physicians without hospital privileges or appointments must of necessity confine themselves to office practice and home visits, and

WHEREAS, free choice of physicians is a right assured the public; such right is rendered meaningless if the physician chosen does not have hospital privileges; all licensed physicians must have access to serviceable hospitals; the concept of the open staff is an indispensable and inseparable corollary to the concept of the patient's free choice of physicians, and

WHEREAS, since organized medicine has for years advocated that all licensed physicians belong to their county, state and national organizations, thus providing the mechanism to insure that a legal and ethical type of medicine is practiced, it is equally the obligation of organized medicine to see that physicians have hospital privileges so that, through daily contacts with their peers, physicians will be stimulated to practice the best medicine; the physician excluded from a hospital appointment is handicapped in his efforts to secure continuous training to serve his patients adequately, and

WHEREAS, the work and procedures performed by any physician should be in keeping with his training, experience and ability and

WHEREAS, such training, experience and ability are demonstrable in more ways than by a certificate of fellowship or certification by a specialty board, now, therefore be it

RESOLVED, that the House of Delegates of the Medical Association of Georgia

(1) Affirm the desirability in the public and professional interest, of every licensed medical physician of good standing, being assured admitting and staff privileges in at least one public accredited full facility hospital, such staff privileges to be commensurate with the qualifications and experience of the physician and subject to the requirements of stipulated activity in the educational, clinical and operational functions of the hospital; and also

(2) Affirm that every qualified licensed medical physician on the staff of any accredited hospital should be permitted to perform in that hospital all work and procedures for which he is qualified through training, experience and demonstrated ability, regardless of his association or lack of association with any specialty group or board, and that no accredited hospital should deny such privileges to any physician solely because of lack of association with a specialty group or board; and also

(3) Affirm that a section on The General Practice of Medicine be established in each hospital where feasible for the purpose of furthering the education of its members, to serve the welfare of the patients and to help its members more fully participate in staff and hospital activities; and be it further

RESOLVED, that a copy of this Resolution be sent to the Administrator and the Chief of Staff of every accredited hospital in Georgia, to The American Medical Association, to The Joint Commission on Accreditation of Hospitals and to The American Hospital Association.

REFERENCE COMMITTEE RECOMMENDATION—In considering this Resolution in detail, both in open hearing and Executive Session, your Committee heard many points of view. Based on the testimony heard, it concluded that the application of the Resolution should be expanded to include all licensed doctors of medicine.

The Committee felt that the Resolution was overly long and tended to be redundant on occasion. Accordingly, it did extensive rewriting and recommends the adoption of Resolution No. 3 as amended.

The Committee moves to amend the Resolution by deleting all the WHEREASES and substituting the following:

WHEREAS, every American citizen expects and demands medical and hospital care within a reasonable distance of his community; and

WHEREAS, many American people seek medical care through a doctor of medicine of their own choice and rely on his treatment and recommendations when they or their family are ill; and

WHEREAS, a doctor of medicine cannot adequately diagnose or treat some of the illnesses of his patients without access to a hospital; and

WHEREAS, the patient is denied freedom of choice of doctor of medicine where the doctor of medicine is denied access to hospital facilities solely because he lacks certification by a specialty board; and

WHEREAS, a doctor of medicine will be stimulated to practice better medicine through education and contact with other doctors of medicine in a hospital; and

WHEREAS, a doctor of medicine's experience, abil-

ity and training can best be judged by his treatment or management of his patients; and

WHEREAS, board certification is not the only method of determining or measuring medical competence or judgment.

The Committee moves further to amend Resolution Number 3 by striking lines 60 through 63 and inserting in place thereof the following:

"and regardless of employment by or association with persons who are already members of the particular hospital staff."

With the foregoing amendments your Committee recommends approval of Resolution Number 3.

HOUSE OF DELEGATES ACTION—Adopted the Reference Committee recommendation as presented.

Resolution No. 4

LEGISLATION CONCERNED WITH LICENSING CLINICAL LABORATORIES AND CLINICAL LABORATORY PERSONNEL

B. H. Hardman, M.D.
For Hall County Medical Society

WHEREAS, pathology and clinical pathology are recognized medical specialties, and

WHEREAS, the availability and results of laboratory procedures frequently are of vital significance in all areas of patient care, and

WHEREAS, it is a proper function of organized medicine to consider and influence legislation related to all aspects of patient care, and

WHEREAS, three bills are currently pending in the House of Representatives of the General Assembly of Georgia involving licensure of clinical laboratories and clinical laboratory personnel, and

WHEREAS, a special committee composed of members of the House of Representatives of the General Assembly has been formed to study conditions which exist in laboratories in the State as well as procedures and practices being used by the laboratories in the State, and

WHEREAS, this committee will make recommendations relating to legislation concerned with licensing and regulation of laboratories in Georgia,

NOW THEREFORE BE IT RESOLVED: That the Medical Association of Georgia through its appropriate committee or committees study all aspects of such legislation and make recommendations to the legislative study committee of the House of Representatives concerning the need for and the type of legislation which might bring about improvement in medical care in the State.

REFERENCE COMMITTEE RECOMMENDATION—Your Reference Committee approves the adoption of this Resolution and wishes to emphasize the desirability of passage of legislation similar to H.B. 755 introduced in 1967 and now being studied by an interim Study Committee of the Georgia General Assembly.

HOUSE OF DELEGATES ACTION—Adopted the Reference Committee recommendation as presented.

Dr. Jones then reported that this concluded the report of the Reference Committee No. 2, and moved for the adoption of his report as a whole with appreciation to the members of his Committee. This motion was duly seconded and approved.

Report of Reference Committee No. 3

Edwin C. Evans, M.D., *Chairman*

(The following reports as presented to this Reference Committee are printed in full with the Reference Committee's recommendations and the action pursuant to them taken by the House of Delegates.)

Chairman Evans reported to the House that reports and resolutions referred to Reference Committee No. 3 were considered by the Committee which met at 2:30 p.m., Oak Room, Augusta Town House Motor Inn, Augusta, on May 6, 1968. Members of the Committee present included: Edwin C. Evans, Atlanta, Chairman; H. G. Davis, Jr., Sylvester, Vice Chairman; A. C. Martinez, Milledgeville; M. A. Hubert, Athens, and Rupert H. Bramblett, Cumming.

President-Elect

Charles R. Andrews, Jr., M.D., *Canton*

The President-Elect of the MAG has attended all meetings of Council, all but two of the regular and called meetings of the Executive Committee, and has served as a member of the Special Finance Committee. Concerning the latter, Dr. Charles T. Cowart, Chairman of the Committee, deserves special recognition for his efforts in this study. Your President-Elect was in attendance at the Annual and Clinical Sessions of the AMA and at these meetings special time was devoted toward working with our delegates. As Representative from the Ninth District, I also attended the legislative meeting in Washington, D. C.

It has been a privilege for me to have served in this capacity during the past year.

RECOMMENDATIONS AND/OR IDEAS FOR CONSIDERATION

1. It is recommended that the treasurer be made a voting member of Council and Executive Committee.

2. It is recommended that travel expenses be alloted to the President-Elect for AMA sessions. With the outstanding activities of our Georgia Delegation, it is becoming more and more important that this office continue to work closely with our delegates on the AMA level.

3. It is felt that some committee should be specifically designated to create closer alliance with the SAMA Chapter in Georgia. These students should have the opportunity to obtain a better insight into the activities of organized medicine and a better opportunity to observe the practicing phase of their future lives. They are almost totally guided up to this point by educational minds.

4. It is hoped that the Educational Committee will again pursue another bi-annual conference on medical education during the coming year. The past two conferences have been most enlightening and many problems have been aired for the improvement of medicine in general.

5. It is hoped for and anticipated that soon after committee appointments are made there will be a one day conference or conclave of all committees. It is felt that this will strengthen our committee activities and give committee members better opportunity to understand their assignments.

6. Efforts will be made to stimulate more activity by the Deputy District Councilors. It is again felt that this is another phase in strengthening our organization.

7. It is again recommended that serious attention be given to the reports of the Special Finance Committee and the MAG Headquarters Expansion Committee.

REFERENCE COMMITTEE RECOMMENDATION—Your Reference Committee recommends approval of the report of the President-Elect and all of its recommendations except No. 1, since other ex-officio members do not vote, and since the office of Treasurer is appointive rather than elective.

HOUSE OF DELEGATES ACTION—Adopted the Reference Committee recommendation as presented.

First Vice President

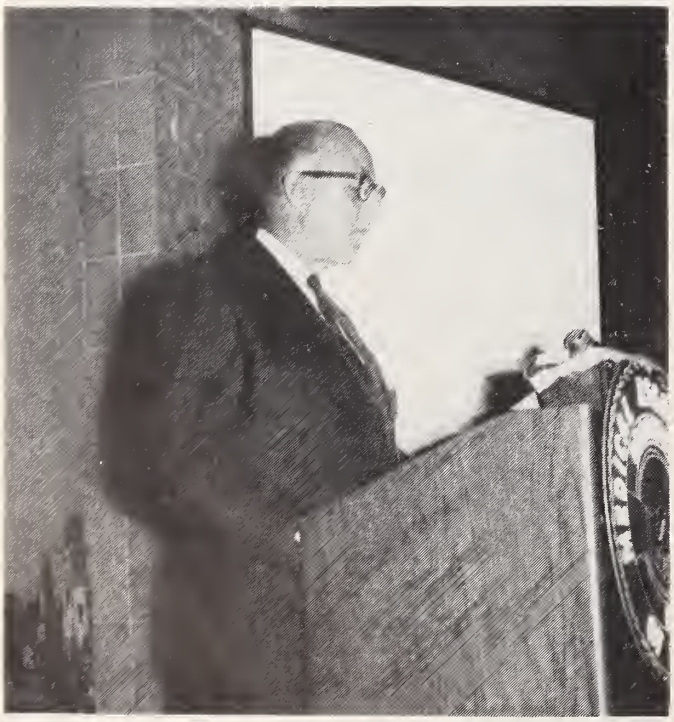
M. C. Adair, M.D., *Washington*

It has been my pleasure to participate in most of the Executive Committee sessions and in all but one of the deliberations of Council.

I continue to be impressed by the devotion and dedication of the many officers, committee members, and staff of the Medical Association of Georgia.

I urge the participation of more and more younger members in the affairs of organized medicine. New viewpoints and fresh ideas are needed in our deliberations.

Let us all assume our responsibilities for the delivery of health care, so that we physicians may remain in control of health matters.



United States Senator Paul Fannin of Arizona delivered a talk entitled "Politics Without Doctors Is Bad Medicine" before the General Assembly.

REFERENCE COMMITTEE RECOMMENDATION—Your Reference Committee recommends the approval of the report of the First Vice President.

HOUSE OF DELEGATES ACTION—Adopted the Reference Committee recommendation as presented.

First District Councilor

C. E. Bohler, M.D., *Brooklet*

As first District Councilor I have attended all called and scheduled meetings of the Council.

I have attempted to keep all local societies in the First District abreast of MAG business and Council actions.

The First District Meeting was held April 24 at the Holiday Inn in Statesboro.

Counties and Secretaries	Members December 31, 1967 MAG	Members December 31, 1967 AMA Dues Paying Only	Members December 31, 1966 MAG	Members December 31, 1966 AMA Dues Paying Only
Bulloch-Candler-Evans				
Curtis G. Hames				
Claxton	18	17	16	15
Burke				
Charles G. Green				
Waynesboro	9	6	9	5
Emanuel				
H. R. Frost				
Swainsboro	9	7	9	8
Jenkins				
A. P. Mulkey, Sr.				
Millen	3	3	3	3
Laurens				
J. J. Skinner				
Dublin	40	19	42	19
Screven				
W. R. Kent				
Sylvania	5	5	5	5
Southeast Georgia				
T. R. Nobles				
Lyons	25	18	27	18
Tri-County				
C. K. Winthrup				
Hinesville	3	3	4	3
	112	78	115	76

REFERENCE COMMITTEE RECOMMENDATION—Your Reference Committee recommends the approval of the Report of the First District Councilor with commendation for his efforts in participating in all called and scheduled meetings of the Council.

HOUSE OF DELEGATES ACTION—Adopted the Reference Committee recommendation as presented.

Finance

C. E. Bohler, M.D., *Chairman*

The MAG Committee on Finance met jointly with the Executive Committee in November, 1967 for the purpose of formulating the Association's budget for the calendar year 1968.

In the process the Committee carefully reviewed MAG's outstanding obligations, actual and anticipated commitments, sources of income, and requests from Association Committees for plans and projects for 1968.

The proposed budget was subsequently submitted to

the Council at its December meeting and approved as published with this report.

You will note that a deficit of $26,000 has been budgeted for the current year. This deficit exists by reason of the fact that the budget does not reflect anticipated reimbursement of expenses.

During 1968 the final annual payment of $3,000 will be made on the Headquarters Office Building mortgage and at that point MAG will assume unincumbered title to the building and property.

I am happy to report to the House of Delegates that the financial condition of the Association continues very favorable.

SUMMARY-COMPARISON OF BUDGETED AND ACTUAL OPERATIONS

THE MEDICAL ASSOCIATION OF GEORGIA
Period January 1, 1967 to November 30, 1967

	1967 Budget	*Actual Jan. 1-Nov. 30, '67*	*1968 Proposed Budget*
INCOME			
I. (a) MAG Dues	$120,000.00	$120,740.00	$123,000.00
(b) Int. & AMA	5,500.00	8,537.44	8,500.00
(c) GP Service	3,250.00	2,708.30	3,250.00
II. ANNUAL SESSION	7,875.0	9,225.00	7,875.00
III. JOURNAL	57,000.00	45,141.83	55,000.00
Sub Total	$193,625.00	$186,352.57	$197,625.00
IV. CONTINGENT			
1966 Excess	13,079.53		
Trans. fr Opr. Cap.	10,000.00	23,079.53	
	$216,704.53	$209,432.10	
EXPENSES			
I. (a) Fixed Allotments	$ 23,441.20	$ 14,969.60	$ 22,280.80
(b) Assoc. Office	115,125.50	100,598.81	128,961.88
(c) Assoc. Boards	18,190.00	13,673.09	22,980.00
(d) Rel. MAG Activities	1,725.00	579.65	1,525.00
(e) Cont. Fund 1966	320.78		
Trans. fr Opr. Cap.	10,000.00	8,305.61	
II. JOURNAL	47,902.05	41,513.08	48,210.60
	$216,704.53	$179,639.84	$223,958.28
			$ 26,333.28†
LIQUID FUNDS AVAILABLE			
I. Cash in Bank		$ 12,657.54	
C & S (Matured 12/1/67)		10,000.00	
II.	*Building*	*Equipment*	
Fulton Fed. Sav. & Loan	$ 8,400.00	$ 698.75*	
Peachtree Federal	3,600.00	400.00	
(Depreciation Savings Acct.)			
III. Savings Accounts			
American Bank of Atlanta		$ 15,000.00	
Atlanta Fed. Savings		15,000.00	
C & S National Bank		50,000.00	
Standard Federal		10,000.00	

BUDGETED AND ACTUAL OPERATIONS

I. (a) FIXED ALLOTMENTS			
Payment on Mortgage	$ 4,000.00		$ 3,000.00
Int. on Mortgage	350.00		150.00
MAG Atty. Exp.	150.00	$ 150.00*	300.00
MAG Atty. Ret.	4,800.00	3,600.00	4,800.00
Pension Payments	2,400.00	1,450.00	1,800.00
Pres. Honorarium	2,400.00	1,200.00	2,400.00
Annual Audit	700.00	700.00	1,500.00
Taxes	3,500.00	4,094.26	4,100.00
Retirement Cont.	4,691.20	3,688.34	3,780.80

* *Postage machine replaced*
† *Deficit*

	1967 Budget	Actual Jan. 1-Nov. 30, '67	1968 Proposed Budget
Retirement Trustee	150.00	87.00	150.00
Woman's Auxiliary	300.00		300.00
	$ 23,441.20	$ 14,969.60	$ 22,280.80
(b) ASSOCIATION OFFICE			
Salaries	$ 77,750.00	$ 71,290.00	$ 86,120.00
Ins. & Bonds	2,850.00	2,760.37	2,950.00
Payroll Tax	3,325.50	2,405.31	3,551.88
Travel-President	1,500.00	1,093.60	1,500.00
Travel-Office	4,000.00	3,707.10	4,500.00
Travel-Del., Sec., AMA Ann. & Clin. Session	3,100.00	1,422.64	4,500.00
Alt. Del. Transp.	2,650.00	1,048.24	3,420.00
Maint. & Repairs			
Building	750.00	753.94*	750.00
Equipment	600.00	742.97	600.00
Tel. & Tel.	4,000.00	3,664.31	4,500.00
Depreciation			
Building	2,000.00		2,000.00
Equipment	650.00		650.00
Postage	2,750.00	2,750.00*	3,500.00
Office Supplies	3,000.00	3,708.53	3,500.00
Jan. Serv. & Supp.	2,200.00	1,840.98	2,620.00
Meetings	800.00	131.66	600.00
Dues & Sub.	400.00	355.00	400.00
Heat, Light & Water	2,500.00	2,625.58	3,000.00
Sundry	300.00	298.58	300.00
	$115,125.50	$100,598.81	$128,961.88
(c) ASSOCIATION COMMITTEES			
Standing			
Annual Session	$ 7,850.00	$ 7,064.67	$ 8,730.00
Professional Conduct	50.00		50.00
Traffic Safety	50.00		1,150.00
Special			
AMA-ERF	35.00		225.00
Blood Banks	50.00		25.00
Cancer	100.00		25.00
Disaster Medical Care	200.00		100.00
Hospital Activities	200.00		200.00
Insurance & Economics	50.00		200.00
Legislation	2,250.00	2,250.00*	2,500.00
Mat. & Inf. Welfare	450.00	104.62	450.00
Medical Education	1,200.00	852.49	400.00
Medical Ethics	50.00		
Med. Review and Nego.	50.00		50.00
Medicine and Religion	250.00	168.84	250.00
Mental Health	230.00	162.93	50.00
Nursing Liaison	50.00		50.00
Occupational Health	300.00		300.00
Paramedical Study (see Cont.)			1,500.00
Physician-Lawyer Liaison	50.00		
Public Service	1,925.00	1,632.85	2,050.00
Rural Health	800.00	345.94	1,175.00
School Child Health	1,500.00	1,048.59	1,500.00
Separate Billing	100.00		50.00
Tal. Hospital Liaison	100.00		
Vol. Health Agencies	300.00		300.00
Special Activities			50.00
Headquarters Expansion			50.00

** See Contingent*

	1967 Budget	Actual Jan. 1-Nov. 30, '67	1968 Proposed Budget
Crippled Children			50.00
Contribution to GaMPAC			1,500.00
	$ 18,190.00	$ 13,673.09	$ 22,980.00
(d) RELATED MAG ACTIVITIES			
AMA Del. Meeting	$ 800.00	$ 367.20	$ 800.00
Medical Defense	200.00		
Interprof. Conduct	125.00	125.00	125.00
SAMA	500.00		500.00
SMEB	100.00	87.45	100.00
	$ 1,725.00	$ 579.65	$ 1,525.00
(e) CONTINGENT			
1966 Excess	$ 320.78		
Trans. fr Opr. Cap.	10,000.00		
GaMPAC		$1,500.00	
Partition GRMP		3,029.13	
Paramedical Study Committee		713.68	
Speaker's Conference		406.45	
Medicare Equipment		656.63	
Maint. & Rep.—Building		750.00	
Postage		639.52	
Legislation		195.24	
MAG Atty. Expenses		49.14	
AMA-Chambers		128.94	
Wash. Expenses Med. Cont.		236.88	
	$ 10,320.78	$ 8,305.61	
JOURNAL			
Expenses			
Printing	$ 35,000.00	$ 30,296.81	$ 35,000.00
Salaries	8,580.00	7,642.27	9,000.00
Insurance	260.00	230.81	250.00
Payroll Taxes	532.05	367.51	630.60
Engr. & Cuts	1,500.00	1,853.17	1,900.00
Postage	900.00	758.69	1,000.00
Stationery	100.00		100.00
Clipping Service	180.00	150.00	180.00
Add. & Supplies	100.00	34.48	100.00
Sundry	50.00	55.74	50.00
SJAB Conference	200.00		
Retirement Contribution	500.00	123.60	
	$ 47,902.05	$ 41,513.08	$ 48,210.60

REFERENCE COMMITTEE RECOMMENDATION—Your Reference Committee recommends approval of the Report of the Finance Committee with commendation.

HOUSE OF DELEGATES ACTION—Adopted the Reference Committee recommendation as presented.

Professional Conduct

T. A. Sappington, M.D., *Chairman*

Another year the Professional Conduct Committee has not met. One letter of complaint was received—vague and no specific charges—the Doctor's name was not mentioned. The MAG Executive Secretary was instructed to write the man immediately and ask for specific complaints and to assure him that his complaints would be investigated. We have not heard any more from this person. There has been no other activity of this committee.

REFERENCE COMMITTEE RECOMMENDATION—Your Reference Committee recommends approval of the Report of the Professional Conduct Committee.

HOUSE OF DELEGATES ACTION—Adopted the Reference Committee recommendation as presented.

Medical Ethics

M. C. Adair, M.D., *Chairman*

This chairmanship was assumed in November 1967.

One problem has arisen which cannot be solved as yet.

There is a meeting planned in March 1968 and perhaps an answer will be forthcoming. No other news to report.

REFERENCE COMMITTEE RECOMMENDATION—Your Reference Committee recommends approval of the Report of the Medical Ethics Committee.

HOUSE OF DELEGATES ACTION—Adopted the Reference Committee recommendation as presented.

Medical Review and Negotiating

Henry S. Jennings, Jr., *Chairman*

During the year this Committee has continued its activity with meetings, dissemination and assembling data via mail, and further developing relationships with the Workmen's Compensation Board.

VETERAN'S ADMINISTRATION

In accordance with action of 1967 House of Delegates the Committee recommended termination of the letter of agreement with the Veteran's Administration which had established a fee schedule for outpatient (home town) treatment. This notification was accomplished June 8, 1967. It has been learned subsequently that, in so far as possible, the Veteran's Administration has unilaterally developed a method of paying the usual and customary fee for these services in most instances.

MILITARY MEDICARE

Negotiation was held with representatives of Military Medicare May 18, 1967. General Peatfield expressed willingness to follow the concept of payment of usual and customary fees using the same guidelines and principles that were developed in earlier negotiations with John Hancock Mutual Life Insurance Company for payments under Part B of Title XVIII. This was agreeable to the Committee and it was recommended to Council of MAG that such a contract be negotiated.

Subsequently a directive from the Department of Defense ruled that state medical associations would no longer be allowed to serve as fiscal agents in the Military Medicare program. After obtaining an extension of the contract which expired July 1, 1967, considerable effort was exerted by several MAG members, legal counsel, and staff directed toward causing a change in the directive which would have prevented MAG from contracting as fiscal agent. Ultimately these efforts were successful and late in 1967 a contract was signed with Military Medicare continuing MAG as fiscal agent in accordance with the negotiations and recommendations of May 18, 1967.

WORKMEN'S COMPENSATION

The Committee delegated the chairman to continue to explore possibilities of changing the Workmen's Compensation fee schedule. In accordance with this a lengthy meeting was held with representatives of the Board. There was an expression by these representatives of the Board to work toward the payment of fees on a usual and customary basis, and an acknowledgement that an immediate upward revision in the current fee schedule is indicated and possible. Accordingly, information concerning suggested raises in fees is being obtained from members of the Committee. When this data is complete it is planned to meet again with these representatives for further discussion.

SUMMARY

It should be pointed out that in all of the conferences and negotiations undertaken by this Committee that the emphasis of the 1967 House of Delegates relating to the principle of negotiation on the basis of usual and customary fees has been the guide. It should be pointed out that as of this time that the following agencies have adopted the concept of payment of charges on the basis of "usual and customary" fees:

1. John Hancock, Medicare Part B
2. Health Department, Medicaid
3. Military Medicare
4. Vocational Rehabilitation
5. Veteran's Administration

REFERENCE COMMITTEE RECOMMENDATION—Your Reference Committee recommends approval of the Report of the Medical Review and Negotiating Committee with commendation.

HOUSE OF DELEGATES ACTION—Adopted the Reference Committee recommendation as presented.

Paramedical Study

John T. Godwin, M.D., *Chairman*

The activities of this committee were expanded greatly during the past year. Local recruitment committees have been formed in each congressional district and supplied with information concerning health careers. Kodachrome slides, depicting many of the various health careers, have been supplied to each chairman. Some of the recruitment committees have functioned well; others have been less diligent in their efforts. It is believed that the overall effort has been good and in time will result in an increase in individuals entering the allied health professions.

This effort has been greatly assisted by Mr. Arthur Arseneault, Research Associate of the Georgia Science and Technology Commission, and Mr. William V. Wallace of the Medical Association of Georgia.

The formation of a central agency was discussed at a recent meeting of the major private and governmental organizations for the purpose of stimulating interest in health careers and providing services which would facilitate the entry of qualified persons into health careers in Georgia. At this meeting, a steering committee was formed which is chaired by the writer. An organizational meeting was held and committees appointed to study all areas for the formation of the agency, which has been designated Health Careers Council of Georgia. This agency will be an independent organization, housed in its own quarters. It is anticipated that monies for supporting the organization will be obtained from major health organizations and others who might wish to contribute. The Georgia Hospital Association is making an annual contribution of $5,000 for this project.

RECOMMENDATIONS

1. The Medical Association of Georgia continue its participation in the Health Careers Council of Georgia and that funds be appropriated annually for support.

2. Financial support be continued for the district chairmen and that their activities be commended and strongly encouraged.

3. The title of the committee be changed to Allied Health Careers Committee.

REFERENCE COMMITTEE RECOMMENDATION—Your Reference Committee recommends approval of the Report of the Paramedical Study Committee and its three recommendations, with an additional recommendation requesting the Council to consider strong financial support for the Health Careers Council of Georgia. This recommendation is based upon the tremendous potential this new organization offers in recruiting and placing medical manpower which stands as one of our most pressing problems. We further recommend that the hard work of the Chairman of the Committee be recognized and commended.

HOUSE OF DELEGATES ACTION—Adopted the Reference Committee recommendation as presented.

Ad Hoc Committee on Special Finance

CHARLES T. COWART, M.D., *Chairman*

The 1967 House of Delegates directed Council to appoint a Special Finance Committee, and gave the following charge to the Committee: ". . . to study the finances of MAG and make recommendations back to the House of Delegates at their 1968 meeting regarding any suggestions for dues increase, altered spending policies, and any other matters concerning themselves with MAG income and disbursements."

The first meeting of the Medical Association of Georgia Ad Hoc Special Finance Committee was held on August 29, 1967. It was noted that MAG dues had been raised from $25.00 to the present level of $40.00 in 1958. We have carried on our expanded activities and absorbed our increasing costs with this $15.00 raise for nine years. In 1966 we experienced a $14,000 deficit which was covered by carry-over of funds from the preceding year. We have generally held reserve (savings) accounts of $80,000.

PAST FINANCIAL SITUATION

1960-1966

1960	*1961*	*1962*	*1963*	*1964*	*1965*	*1966*
			Active Members			
	2,577	2,646	2,732	2,841	2,925	2,989
			Increase			
		69	86	109	84	64
		(2.17%)	(3.25%)	(4%)	(2.95%)	(2.2%)
Average Increase 82.40		Average % Increase 3.02%				
			Income From Dues ($40.00 Per Year)			
$100,192	$102,500	$105,875	$109,770	$113,615	$117,047	$121,425
			Increase			
	2,407	3,375	3,895	3,845	3,432	4,378
	2.4%	3.29%	3.68%	3.5%	3%	3.75%
Average Increase $3,555.50		Average % Increase 3.27%				
			Total Income			
$163,314	$152,821	$156,571	$159,302	$156,755	$166,895	$195,678
			Increase or Decrease			
	-$ 10,493	+$ 3,749	+$ 2,731	-$ 2,546	+$ 10,140	+$ 28,783
	-6.86%	+2.45%	+1.74%	-1.6%	+6.46%	+17.24%
Average Increase $5,394.03		Average % Increase +3.24%				
			Income Other Than Dues			
$ 63,122	$ 50,321	$ 50,696	$ 49,532	$ 43,140	$ 49,848	$ 74,253
Average $54,416.29						
			Expenses			
$150,033	$140,736	$142,343	$148,431	$155,599	$156,610	$182,599
			Increase or Decrease			
	-$ 9,296	+$ 1,606	+$ 6,088	+$ 7,168	+$ 1,010	+$ 25,989
	-6.6%	+1%	+4.28%	+4.83%	+0.65%	+16.6%
Average Increase $5,428.82		Average % Increase +3.46%				
			Income Over Expenses			
$ 13,281	$ 12,084	$ 14,228	$ 10,870	$ 1,155	$ 10,285	$ 13,079

PROJECTED FINANCIAL SITUATION

1967-1974

1967	*1968*	*1969*	*1970*	*1971*	*1972*	*1973*	*1974*
			Membership				
3,071	3,153	3,235	3,317	3,399	3,481	3,563	3,645
			Income From Dues ($40.00 Per Year)				
$124,980	$128,535	$132,080	$135,635	$139,195	$143,745	$147,300	$150,855
			Total Income				
$201,072	$206,466	$211,860	$217,254	$222,648	$228,042	$233,436	$238,830
			Expenses				
$188,028	$193,457	$198,886	$204,315	$209,744	$215,173	$220,602	$226,031
			Income Over Expenses				
$ 13,044	$ 13,009	$ 12,974	$ 12,939	$ 12,904	$ 12,809	$ 12,834	$ 12,799
			Income From Dues ($50.00 Per Year)				
	$157,650	$161,750	$165,850	$169,950	$174,050	$178,150	$182,250
			Income Over Expenses ($50.00 Dues)				
	$ 18,609	$ 17,280	$ 15,951	$ 14,622	$ 13,293	$ 11,964	$ 10,635
			Income From Dues ($55.00 Per Year)				
	$173,415	$177,925	$182,435	$186,945	$191,455	$195,965	$200,475
			Income Over Expenses ($55.00 Dues)				
	$ 34,374	$ 33,455	$ 32,536	$ 31,617	$ 30,698	$ 29,779	$ 28,860
			Income From Dues ($60.00 Per Year)				
	$189,180	$194,100	$199,020	$201,940	$208,860	$213,780	$218,700
			Income Over Expenses ($60.00 Dues)				
	$ 50,139	$ 49,630	$ 49,121	$ 48,612	$ 48,103	$ 47,544	$ 47,085

INCOME AND EXPENSE CHANGES 1960-1966

	1960	*1966*	*Difference*	*% Diff.*
		Income		
Dues	$100,192.50	$122,425.50	$21,233.00	+ 21
Interest	342.50	5,996.34	5,553.84	+160
AMA Refund	595.38	1,427.66	832.28	+140
Exhibits(Ann. Sess.)	9,100.00	7,525.00	-1,575.00	- 21
Journal MAG	51,919.04	58,197.84	6,278.80	+ 12
		Expenses		
Mortgage Int.	$2,000.00	$ 550.00	-$ 1,450.00	-264
Legal Fees	2,212.74	4,376.24	2,163.50	+ 98
Honorarium	1,000.00	2,400.00	1,400.00	+140
Pension	900.00	1,600.00	700.00	+ 78
		ASSOCIATION OFFICE		
Salaries	32,796.57	60,169.13	27,372.56	+ 83.5
Insurance	1,010.60	1,995.85	985.29	+ 97
Payroll Tax	1,343.68	2,179.72	836.04	+ 63
Travel	4,228.60	10,947.29	6,718.69	+159
Bldg. Maint.	3,170.73	1,331.73	1,838.51	-138
Tel & Tel	2,318.62	4,254.39	1,935.77	+ 83
Depreciation	9,462.67	8,145.08	-1,317.59	- 16
Postage	1,905.81	1,779.16	- 126.65	- 7
Office Supplies	2,842.96	3,368.48	525.52	+ 18
Janitor Serv.	1,223.16	1,504.59	281.43	+ 23
Meetings	694.14	815.16	121.02	+ 17
Dues & Subscript.	219.00	445.00	126.00	+ 57
Total Office	63,488.41	102,647.53	39,195.12	+ 62
Annual Session	11,694.61	6,612.36	-5,082.25	- 77

The chairman attended the budget meeting of the Finance Committee of MAG Council in November 1967. There was noted an increase in the 1968 budget of $17,780 over the 1967 budget. This was in non-reimbursable items.

A joint meeting of the MAG Special Finance Committee and the MAG Headquarters Expansion Committee was held on December 9, 1967. Having been requested to review the headquarters office and look for possible economies there, Dr. Rhodes Haverty reported on the following possibilities:

1. Rent the Woman's Auxiliary room to the Georgia Regional Medical Program for $2,000 to $2,500 per year.
2. Sell two or three additional ads in the *Roster*. This would produce about $900.00.
3. It might be possible to save an additional $1,000 on numerous small items such as combined mailings.

After long and careful discussion, the joint committee agreed on the following recommendations.

1. That no action be taken by the Association regarding an increase in membership dues until such time that actual annual operating costs exceed annual income, or until projected programs are developed which indicate a need.
2. That the headquarters building not be expanded merely for the purpose of attracting tenants for rental income.
3. That needs for building expansion or changes to the existing facility based on the operating needs of the headquarters staff be studied by the new Executive Secretary and brought to the attention of the Headquarters Expansion Committee in January 1968.
4. Both these committees (Headquarters Expansion Committee and the Special Finance Committee) recommend to the House of Delegates that they be continued.

CHAIRMAN'S ADDENDUM COMMENTS

The report as rendered above is the consensus of the Ad Hoc Special Finance Committee. However, there are a few items which the House of Delegates might consider:

1. With the annual dues at $40.00 per year, the projected income over expenses from now until 1974 shows a figure of $13,009 decreasing to $12,799.00.
2. There is a $17,780.00 increase in the 1968 budget, most of which is salaries. And, we have been told that we can expect to have to go higher to retain the experienced personnel we have. It costs us money every time we lose experienced personnel and have to hire new unfamiliar ones.
3. You will note that nearly all of the percentage changes in expenses are increases, and many of these are very large percentages.
4. How long can one Field Representative serve so many county and district societies and individual members over so large a geographical area, and how well? If the need is found to exist for an additional field man, we can expect a salary of $14,000 to $16,000.
5. Does the MAG expect all the money for the MAG Foundation to come from non-medical philanthropies, or should we not contribute a fairly large sum each year from the Association?

REFERENCE COMMITTEE RECOMMENDATION—Your Reference Committee recommends approval of the Report of the Ad Hoc Committee on Special Finance with commendation and with the additional suggestion that Council strongly consider recommending the necessity for a dues increase by the House of Delegates in 1969, since such seems to be indicated now in order to provide flexibility in the consideration of present and future activities. We further recommend that Council give special consideration to the Chairman's addendum comment No. 5 and the idea of an annual contribution to the MAG Foundation.

HOUSE OF DELEGATES ACTION—After considerable discussion regarding the necessity for an immediate dues increase from $40.00 to $60.00, the House of Delegates approved the Reference Committee report as presented.

Headquarters Expansion Study Committee

J. G. McDaniel, M.D., *Chairman*

Your Headquarters Expansion Committee, composed of Dr. John S. Atwater, Dr. F. G. Eldridge, and Dr. J. G. McDaniel, Chairman, was appointed with the charge to study the needs for expanding our Headquarters facility and to investigate various solutions to the problem of growing responsibilities thrust upon the staff in recent years, and the corresponding growth in personnel necessary to accomplish those tasks. By contract with the Department of Defense, the MAG serves as the Fiscal Agent for the Military Medicare Program (CHAMPUS) and the staff necessary to administer that department has increased to eight. As Grantee for the Georgia Regional Medical Program, your Association now houses eleven employees for that program's administration. The central MAG staff including the Journal continues at nine.

MAG has been approached regarding the establishment of a new department very closely allied with our general purposes. The Georgia Regional Medical Program expects to add an additional fifteen employees by August 1, 1968, and the normal expansion of the membership and other routine programs will require space not available in the existing building.

The primary question which your Committee proposes to the Council is: Shall the MAG expand its Headquarters facility to accommodate all its growing programs in one central location, or shall we direct each department to secure its own housing in other locations? In following the latter alternative, adequate space for the central staff and perhaps one department would be available in the existing building.

Your Committee has had in its deliberations the counsel of Thompson and Hancock, Architects, as well as the firm of Marthame Sanders and Company, builders of the existing building which MAG acquired in 1960 at a cost of $185,900. The interior was slightly renovated at a cost of $5,400. The property consists of approximately 32,000 square feet and is estimated to be worth $8.00 per square foot exclusive of the building. Our consultants' recommendations are as follows:

Problem: As set forth by the Medical Association of Georgia, it is necessary to double the size of the existing building at 938 Peachtree Street, N.E. It is also necessary to make certain changes in the existing building in order to have more efficient circulation and relationship of offices. Parking requirements will increase to an eventual total of 60 cars.

Solution: There were four solutions considered:

1. Add 6,000 square feet of floor space in two floors.
2. Add 6,000 square feet of floor space all on the second floor in order to provide more parking space under.
3. Deck over the rear portion of the lot in order to increase the parking.
4. Buy a new lot and build a completely new building.

Recommendation: It is our recommendation that Solution No. 1 be considered. This will provide the office area required and suitable parking for the present. In the future, if parking becomes a problem, a deck can be built as shown on Solution No. 3. This deck can be as large as required to handle up to about 40 more cars.

We recommend that a "Cost Plus a Fixed Fee with a Guaranteed Maximum Amount" contract be negotiated with Marthame Sanders and Company. (See copy of letter from Marthame Sanders and Company which appears below.) Any savings that can be effected as the building progresses will revert to the Owner. Over the years we have found this to be a most satisfactory form of agreement for this type work.

* * *

We have made the following study and prepared budgets of the cost of the four solutions of your office and parking requirements as follows:

Solution Number One (57 Parking Spaces): add two story addition; remodel existing building; grade down and extend parking lot to Cypress Street; remove trees (10); retaining wall south side; curb north side and rear; paving; marking parking lot.

Our estimate of the above work is $175,771.00.

Solution Number Two (65 Parking Spaces): build one story addition above parking lot; remodel existing building ; remove trees; grading to Cypress Street; retaining wall south side; curb north side and rear; paving; marking parking lot.

Our estimate of the above work is $187,771.00.

Solution Number Three (80 Parking Spaces): add two story addition; remodel existing building; add parking deck for 23 cars; cutting trees; stairs to top level; paving lower level; marking parking areas.

Our estimate of the above work is $229,918.00.

Solution Number Four: New site and two story building of 13,900 sq. ft. with 100 parking spaces on lot of 60,000 sq. ft.

Our estimate of the above work is $758,00.00.

We will be glad of the opportunity of working further with you in the solution of your office and parking needs.

* * *

With regard to Solution Number Four, the new construction is considered in terms of $8.00 per square foot property which breaks down to $480,000 for land and $278,000 for the building. Identical construction on land valued at $2.00 per square foot (Executive Park, N. E. 85) would cost a total of $398,000.

The architects estimate two months would be required to complete the necessary drawings and their fee would be eight per cent of the cost of construction including construction supervision. Mr. Marthame Sanders estimates seven months would be required in construction of a 6,000 square foot addition or one year for a new structure. The construction cost estimates above are firm maximums and any savings realized would be deducted from that amount.

Your Committee is indebted to the architects and Mr. Sanders for their assistance to date without renumeration.

RECOMMENDATION:

Your committee, after a study of the alternative proposals, recommends that the Association proceed as expeditously as possible with Plan Number Two, the construction of a 6,000 square foot addition to the existing building at the second story level and improvement of the parking area. We have reached this conclusion based on the following reasons:

1. Our present property is located in an area of increasing land values and should be retained.
2. The program facing the most immediate growth is the Regional Medical Program and the second story addition would enable all GRMP employees to be together.
3. Further expansion in the future would be simplified since first floor improvements could be easily added.
4. Our central Atlanta location, three city blocks from the 10th Street Exit of the North Expressway, makes access convenient from all directions in the State.

Your Committee has not examined the various avenues of finance available to meet the above recommendation but feels that this is a logical forward step for our Association at this time, and one in keeping with the forward attitude displayed in recent years by our Association.

Supplemental Report of Council No. 7

HEADQUARTERS OFFICE BUILDING EXPANSION

F. G. Eldridge, M.D., *Chairman*

The Report of the Headquarters Expansion Study Committee as printed in the Delegates Handbook (page 38-39) recommends that the Association proceed with the construction of a 6,000 square foot addition to the present Headquarters Building and improvement of the parking area located on the Association property.

Since filing this report certain additional facts have come to light which causes the Committee to alter its recommendations as they appear in the Handbook.

The Headquarters Expansion Study Committee in meeting on Saturday, May 4, 1968, voted to recommend to the Executive Committee that the Headquarters Building be expanded by 10,000 square feet, all of which would be located on the second level; that the structure be built on pilings sufficient to support a six story building; and that two floors of parking be constructed to accommodate 120 cars. The approximate cost as supplied by the architects would be $430,000.

On recommendations of the Executive Committee and following an exhaustive review of this matter in consultation with the architects, the Council voted to recommend to the House of Delegates that the Association proceed accordingly.

REFERENCE COMMITTEE RECOMMENDATION—Your Reference Committee wishes to offer its recommendations at this time on both reports which pertain to the Headquarters office Building Expansion; that is, this committee's report and item 16, the Supplemental Report of Council (No. 7). Your Committee

recommends approval of both reports with special commendation for the efforts of Dr. J. G. McDaniel, and wishes to recommend the following amendments to the Supplemental Report: in line 13 strike the next to last word "two" insert there the word "three"; in line 14, strike the number "120" and insert there the number "180"; and in line 15, strike the figure "$430,-000" and insert there the figure "$500,000." (The Headquarters Office Building Expansion report as amended would read in paragraph three ". . . on pilings sufficient to support a six story building; and that the three floors of parking be constructed to accommodate 180 cars. The approximate cost as supplied by the architects would be $500,000.")

HOUSE OF DELEGATES ACTION—Following a slide presentation by Mr. Norman Davis, of Thompson and Hancock, Architects, Speaker Rogers recognized Fleming Jolley, Atlanta, who moved to amend the Reference Committee recommendation by striking the term "six story" and inserting in lieu thereof the words "high rise." In further discussion, it was determined that "high rise" meant up to fifteen stories should the present zoning restriction on a building height of eighty feet be changed. The motion was seconded and adopted by unanimous vote.

Speaker Rogers recognized J. G. McDaniel who suggested that Council be authorized to proceed with additional construction should long term leases become available. This suggestion was moved, seconded and adopted by unanimous vote.

Woman's Auxiliary

MRS. JAMES H. MANNING, *President*

Progress with determination, stamina, cooperation, drive, love and above all purpose has steered our auxiliary far into our theme of "Unlimited Dimensions" this year. New roads have been opened and old routes extended into realms that hold true to what we cherish and believe in so wholeheartedly. I'm speaking, of course, of the medical profession and its great task of protecting the public health and providing the highest type of medical care—and our role here in Georgia in serving as the auxiliary to this medical association. Doctors' wives in this state who belong to our auxiliary will number more than 2,000 this year. These more than 2,000 women have traveled many long miles and worked many long hours to help project concern and sincere interest in matters that pertain to our state's health and well being. Our efforts with the committees on AMA-ERF, Health Careers, William R. Dancy, M.D., Student Loan Fund, International Health, Disaster Preparedness and Safety, Mental Health, Rural Health, and Community Service have been most rewarding with their successful endeavors.

One county auxiliary helped present a symposium on sex education with national authorities as speakers and boasted its registration books included representatives from 15 states as well as having over 25 cities in the State of Georgia represented. Another auxiliary has successfully introduced into its public school system a course on "Operation T and T" or a Time for Teens. The purpose of this being twofold: (1) To offer a course that would provide accurate information from reliable sources to teenagers on body growth and development, boy-girl relationships, and problems of teens (alcohol, smoking, narcotics, and V.D.) and (2) Help strengthen the line of communication between parent and teenager. This particular program was worked out through joint efforts of the auxiliary members, medical society members, school teachers, ministerial associations, Boy Scouts, Girl Scouts, college groups, and YWCA and YMCA members. Another auxiliary is helping to furnish their local county hospital with a complete intensive care unit by presenting fashion shows, teas, and tours of homes in their area. Another small auxiliary has already been responsible this year for mailing hundreds of pounds of soap to world relief hospitals and missions. Still another maintains a loan chest of sick room equipment for indigent patients in their county. One of our large auxiliaries has contributed a major portion of the work in the headstart program in their county. Helping promote and advance health careers have been prime projects of several auxiliaries this year. Other auxiliaries are outstanding with their work in disaster preparedness and safety, mental health, and legislation. Great and wonderful good has been wrought in this state of ours by doctors' wives, and being a part of this organization is a contagious bond which requires us not to sit on our hands, but to spread auxiliary work whenever and wherever the need arises.

RECOMMENDATION

The Woman's Auxiliary would like to take this opportunity to make the following recommendation to the House of Delegates for their consideration. We seek and need desperately more financial aid from the Medical Association of Georgia to help us continue to initiate such programs as mentioned above. Our auxiliary for three years has gone into deficit budgeting and again this year we have had to cut a number of worthwhile projects as well as further limit the budget of some of the committee chairmen. If the Medical Association of Georgia could see fit to finance the publication of our annual report and our state publication *The Pulse Line* we believe our auxiliary could operate on a reasonably sound budget. We solicit your serious consideration on this request.

Mrs. William A. Fuller, Jr., of Augusta, General Convention Chairman for the Auxiliary, Mrs. Henry D. Scoggins, President of the Richmond County Auxiliary, and another Richmond County Auxiliary member staff the Auxiliary registration and information desk.

REFERENCE COMMITTEE RECOMMENDATION—Your Reference Committee recommends approval of the report of the Woman's Auxiliary with commendation and with the additional recommendation that Council include in future annual budgets the cost of publishing the Annual Report of the Auxiliary and the *Pulse Line*.

HOUSE OF DELEGATES ACTION—Adopted the Reference Committee recommendation as presented.

Late Report No. 2

MAG INSURANCE AND ECONOMICS COMMITTEE

HENRY S. JENNINGS, *Gainesville*

KEOGH RETIREMENT PLANS:

During the year much correspondence and conversation concerning various funding mechanisms for Keogh retirement plans has occupied a large part of the Committee's time. Numerous individuals and companies approached the Committee seeking endorsement, approval, sponsorship, or some combination of the above for each one's own interest. The Committee adopted the position that these proposals were available to MAG members as individuals and the formation of a group or trust was not necessary or desirable. The Committee felt that each member of MAG should be free to select his own plan, trustee, mutual fund, and/or financial advisor according to his own individual wishes and financial needs.

The one exception to the above concerned a funding mechanism that could be offered by Prudential Life Insurance Company *only* if a Trust were established. In order to make this avenue available to MAG members, the Committee recommended, and Council approved, the formation of such Trust with no approval, endorsement or sponsorship (by MAG) requested, nor given. Subsequently it has been learned that pending legislation in New York State would allow these retirement programs on an individual basis. As a consequence, the Committee and MAG legal counsel are no longer working toward the creation of such Trust.

The Committee does commend the principle of Keogh Retirement Plans to all MAG members and urges each member to seek information from his own financial or insurance advisor.

ST. PAUL—MERCURY LIABILITY INSURANCE:

After consultation with an independent actuary who had opportunity to extensively review the data of this program, the Committee agreed that there is justification for the Company's recommendations: (1) that a premium increase of 11% be effected and (2) that the number of premium categories be increased from 3 to 4 (in order to give a more equitable distribution of premiums) with the possibility of a further increase to 5 categories after the 1969 review.

It should be pointed out that premiums at present are 43% below "Standard," or Bureau, rates and even with the 11% increase the rates for MAG members will be 36% below Bureau rates.

1967 HOUSE OF DELEGATES RESOLUTION NO. 7 RE PAYMENT FEES TO SURGICAL ASSISTANTS AND HOSPITAL-BASED PHYSICIANS:

The Committee pursued the direction of the 1967 House of Delegates Resolution No. 7 concerning payment of fees to surgical assistants and hospital-based physicians only to ascertain that the Insurance Commissioner's office is unable to require such coverage by insurance companies and that the possibility of a statutory requirement is unlikely. The Committee intends to follow this further with communication with the Health Insurance Council.

REFERENCE COMMITTEE RECOMMENDATION—Your Reference Committee recommends approval of the Report of the Insurance and Economics Committee with commendation.

HOUSE OF DELEGATES ACTION—Adopted the Reference Committee recommendation as presented.

Supplemental Report of Council No. 1

THIRD PARTY PAYMENTS TO TEACHING INSTITUTIONS

F. G. ELDRIDGE, M.D., *Chairman*

By way of giving an interim report on a matter yet unsettled, the Council has attempted over the past several months to resolve the problems imposed by an agreement between Emory University and Grady Memorial Hospital for the delivery of care at Grady Hospital to those patients under Medicare.

Basic to any consideration of this matter is a statement of policy adopted by the Council at its December 1967 meeting. This policy provides, among other things that "A hospital or medical school may not participate in the fees collected for medical services"; and additionally that "Fees for medical services collected by a hospital medical staff or organization representing the medical staff should be distributed solely on the direction of the medical staff without coercion of any kind and in accordance with agreements previously reached by the physicians comprising the medical staff and the hospital or medical school."

Council should point out here that the problem does not arise over the question of the fees collected accruing to any member of the Grady Hospital medical staff. To the contrary, none would. Rather the problem is one of who shall determine how the fees collected are disbursed. The terms of the agreement appear to give too little weight to the policy position that the physicians producing the fees should determine how and for what purposes and projects these fees should be disbursed.

Negotiations are being continued with the hope that some type of non-profit partnership comprised of the members of the medical staff similar to that adopted by the Talmadge Hospital several years ago can be achieved.

As an interim report this is filed for the information of the House of Delegates.

REFERENCE COMMITTEE RECOMMENDATION—Your Reference Committee recommends approval of the Supplemental Report of Council on Third Party Payments to Teaching Institutions with the additional recommendation that the Council be supported and endorsed in its further efforts to resolve this matter.

HOUSE OF DELEGATES ACTION—Adopted the Reference Committee recommendation as presented.

INCOMING PRESIDENT'S ADDRESS

CHARLES R. ANDREWS, JR., M.D., *Canton*

The Medical Association of Georgia is an organization of doctors who have gathered together in the interest of the health of mankind. We are a group of physicians who think our standards should be held in the highest esteem. We recognize there are many facets in the healing arts. As allopathic practitioners of medicine, we should demand that the American public and the people of the world have the best of medical care that can be afforded. I quote: "The objects of this Association shall be the advancement of medical knowledge, the elevation of professional character, the extension of the bounds of medical science, the promotion of all measures adapted to relieve suffering humanity and to protect the lives and improve the health of the community." With these ideas in mind, it is felt that the people will be better served and the doctors can give better service if we in Georgia are well organized. This statement in no means refers to a monopolistic group, but to the organization of men who are interested in the Welfare of all mankind. With these views, it is my hope that during the coming year we can improve and strengthen the organization of our Medical Association within our group of Georgia Doctors.

The Medical Association of Georgia is composed of Component Societies throughout the State. These societies are made up of the individual doctors who form the basic roots of our organization. The most important element in the Medical Association of Georgia is the individual doctor. Whether they be small or large, our Component Societies are extremely important. Naturally without them, there would be no District Societies. Unfortunately, along the line, the individual doctor does not realize his responsibility in the organization, and some of the smaller societies do not think that they hold an outstanding position within our organization. This line of thinking leads to the weakening of our total Medical Society structure. Never forget that our organization is a truly democratic group and our representatives, from the individual Component Societies, form the House of Delegates, the group that really runs the organization. Unfortunately, many of our smaller societies do not realize the utmost importance of their representatives, who should always be present at the House of Delegates meeting. They are the men who will truly represent our group; and when we have sincere and interested representatives in the House of Delegates from each Component Society, all will have a true insight into the operation of our Medical Association of Georgia.

Forgive me if I repeat basic principles that you already know; however, I feel that to improve our organization it is very urgent that all the members understand how we have been developed, and how we operate. The main theme of my plan of action with regard of the future of the Medical Association of Georgia has to do (1) with basic organization, and (2) importance of organization which must start at the grass roots. We are in a scrap for our very existence; let us wake up and become aware. If we are in a little corner, let's get out. Let us discover our problems and use organization to solve them.

It is my impression that most of the doctors in the rural areas do not realize the importance of their position in our Medical Association. The organization of Component Societies into District Societies is again another most important step in operational procedures. There is a representative from each District on the Administrative Council, and of course, in a democratic manner, Component Societies have Council representatives in proportion to their membership. The members elected to the House of Delegates from our Component Societies form the governing body of the Medical Association of Georgia. Many times these positions are taken too lightly, because the individual doctor does not understand the important position he plays in our organization.

Doctors are privileged individuals in a privileged class, let there be no doubt about it. But to be worthy of this position, we must have total respect for our contemporaries, and complete dedication to our fellow man.

Today as always the organization of medicine is parallel to the organization of mankind and we can get back to the old argument, which is more important—Heredity or Environment. We have inherited the symbol of Aesculapius, the principles on which it stood, and the oath of Hippocrates, and we cannot get away from these basic principles. However, our modern day environment has certainly improved our medical outlook and given us advances: not only beyond the dark ages, but much beyond our earlier so called enlightened era. A good many years ago I was acquainted with some older doctors and some new young doctors who thought they knew all the answers. Today, I see confused older doctors and younger doctors who do not know all the answers even in these most enlightened times. Therefore, we should open our eyes and re-evaluate ourselves in the light of this present day. "There may be nothing new under the sun, but

Incoming President Charles R. Andrews, Jr., of Canton delivers his address to the joint House of Delegates and General Business Session on Monday morning.

we had better keep our eyes open and look out for those things which are descending upon us."

Doctors, look at reality and make every effort you can to correct the image we have created with the public. Many of us have fallen in the trap of floating with the tide. The fault is not all ours, but the burden of proof is ours—and be not mistaken, sometimes we could improve. And herein a word to the wise should be sufficient. A well known Georgia barrister once quoted "Hope springs eternal from the human beast"; and I thought that if the doctor's heart is not "the pierian spring" May The Good Lord Help Us.

It is hoped that you will kindly indulge me in a bit of personal background which has to do with my heredity and much with my basic logic. First of all my maternal grandfather, A. L. Waldo, in the early 1930's told me that perhaps he was not a religious man in the concepts of some people with regard to attending church. But he assured me that he had basic feelings and beliefs which paralleled the Christian way of life (he lived this life) and truly believed that the Bible was a good book with basic principles for people to follow. At this time someone in the higher echelons of the Federal Government was recommending that farmers be paid by the Federal Government to raise pigs and kill them. Grandpa referred to the biblical parable of the seven years of plenty and the seven years of want. He told me that he might not live long enough to see the repercussions of this situation, but assured me that I would see people going hungry and regret the fact that food was wasted when it could have been stored and given to the poor. This is not mentioned in the recent light of selfish interests who are apparently demanding the Government subsidize them. It is mentioned because we need proper utilization of medical manpower and proper distribution.

From the standpoint of our organization I do not feel that enough attention has been given to our undergraduates and immediate postgraduate doctors. The bulk of their teaching is by salaried doctors who have not been in the competitive practice of medicine with its different financial position and, I think, its different fraternal relationship between doctors and doctors, and doctors and patients. It is hoped that more action will be taken along this line. "If you are planning for one year—grow grain; if you are planning for ten years—grow trees; if you are planning for one hundred years—grow men."

In the third decade of this century my father, Dr. Charles R. Andrews, Sr., before I had entered Medical School, told me that I had been taught about the molecule and the atoms. At that time he called my attention to the automobile which had been run by water (The Stanley Steamer), and he fully believed that undoubtedly someone had already invented a device to separate Hydrogen and Oxygen from water and properly combine these elements to form a combustion engine. (If this be true I wonder what the oil tycoons did with the inventor.) Nonetheless, he told me there was unlimited energy in things we considered as dead or inert substances. He pointed to an old chair and stated the wood was dead to my line of thinking, but that within the molecules and atoms of this apparently dead substance lay unlimited energy. At the time I did not have the comprehension of his vision. But today any other fool knows that everybody is splitting atoms. Vision is an essential element in a vital organization. The continued existence of the Medical Association of Georgia depends on how well we anticipate the problems of the future.

About twenty years ago my uncle, Governor John M. Slaton, told me that back in 1914 when governor he ran the State of Georgia on a budget of five million dollars. This conversation, some twenty years ago, was at a time when some of the politicians were claiming that a seventy-five million budget was outrageous. When he was Chief of State the ad valorem tax was cut and there was not deficit spending. He readily admitted that times and economies had changed, but he questioned the necessity for the large difference in cost of operations. Following this example, the Medical Association of Georgia should continue its sound fiscal management.

These three examples were stated to illustrate the importance of the basic principles of conservation—vision—and intelligent operational management of our organization. A compatible combination of all three is necessary for us to function at our best.

Talking about heredity and environment, we can also talk about facts and fantasies. The difference between facts and fantasies is what goes on, and what one thinks ought to go on. We must adapt to changing times and grasp each day's challenge with a positive approach. "Time is the Raw Material for everything. It is our whole life coming to us in little pieces. Time is very old but every new morning is young. Each day is a new discovery and the greatest discovery you can make is yourself."

Keep these general ideas in mind. Through the House of Delegates, and the function of Council and its Committees, they will be materialized. Every obligation of the Medical Association of Georgia and each member cannot possibly be designated here, but we will be cognizant of all. Let me repeat, we are in a scrap for our very existence; let us wake up and become aware. If we are in a little corner, let's get out. Practice good medicine always, but do not forget our position in and obligation to our community. Efficient organization will aid every doctor in this endeavor.

Let us not be swayed by the hysterical tendencies of the tumult, but look again at the solid foundation given by our forefathers as a heritage beginning with the original Great Healer.

Doctors, let's take a second look at ourselves—and re-dedicate ourselves. Perhaps the answer to all our problems is just that simple.

REFERENCE COMMITTEE RECOMMENDATION —Your Reference Committee recommends approval of the Incoming President's Address with commendation.

HOUSE OF DELEGATES ACTION—Adopted the Reference Committee recommendation as presented.

Resolution No. 6

METHOD OF ELECTING OFFICERS OF THE MEDICAL ASSOCIATION OF GEORGIA

W. M. Watkins, M.D.

For Laurens County Medical Society

WHEREAS, the present method of electing officers of the Medical Association of Georgia usually disenfranchises four/fifths of the members of MAG; and

WHEREAS, the present method of election is a survival of the horse and buggy days, and

WHEREAS, no State Medical Association of comparable size and medical population uses such method, and

WHEREAS, the present method of elections is conducive to manipulation of the vote by the local medical society where the annual sessions are held.

NOW THEREFORE BE IT RESOLVED, by the Laurens County Medical Society in regular session assembled, that the House of Delegates of the Medical Association of Georgia instruct the Constitution and By-Laws Committee of the Medical Association of Georgia, to introduce at the 1969 Annual Session, Constitution and By-Law changes that would make the House of Delegates the representative elective body; for the election of the officers of the Association and the Delegates and Alternates to the A.M.A.

REFERENCE COMMITTEE RECOMMENDATION —Your Reference Committee recommends disapproval of Resolution No. 6 with an amendment that the House of Delegates instruct the Executive Committee of Council to appoint an Ad Hoc Committee on Elections to study the alternative methods of electing MAG officers.

HOUSE OF DELEGATES ACTION—Adopted the Reference Committee recommendation as presented.

Supplemental Report of Council No. 8

LEGAL IMMUNITY FOR PHYSICIANS ON UTILIZATION REVIEW COMMITTEES

F. G. Eldridge, M.D., *Chairman*

Pursuant to Public Law 89-97 (Medicare) Utilization Review Committees must be established and maintained.

It has been noted with concern by the Council, based on reports received, that such committees are on occasion reluctant to release to the insurance carriers certain of their recommendations out of fear that to do so would place them in legal jeopardy.

Council took the view that it was not sufficient that financial protection from liability may be accorded in certain mal-practice insurance policies. Rather, it took the position that in the performance of one's job as a member of a Utilization Review Committee statutory immunity should be given so long as "good faith" was exercised by the Committee.

Accordingly, Council voted to recommend to the MAG House of Delegates that the legislative Committee be instructed to draft legislation for introduction before the 1969 General Assembly, the effect of which would be to accord legal immunity from liability to members of Utilization Review Committees in the performance of their official Committee duties.

REFERENCE COMMITTEE RECOMMENDATION —Your Reference Committee recommends approval of Supplemental Report No. 8.

HOUSE OF DELEGATES ACTION—Adopted the Reference Committee recommendation as presented.

Dr. Evans then reported that this concluded the report of the Reference Committee No. 3, and moved for the adoption of his report as a whole as amended by the House of Delegates with appreciation to the members of his committee after four and one-half hours of concentrated deliberation. "I wish to thank all who came to share their advice with us, but a special word of commendation is certainly due the members of my committee and Mr. Smith who staffed it, for their stamina and perseverance."

Report of Reference Committee No. 4

J. Watts Lipscomb, M.D., *Chairman*

(The following reports as presented to this Reference Committee are printed in full with the Reference Committee's recommendations and the action pursuant to them taken by the House of Delegates.)

Chairman Lipscomb reported to the House that reports and resolutions referred to Reference Committee No. 4 were considered by the Committee which met at 2:30 p.m., Walton Room, Town House Motor Inn, Augusta, on May 6, 1968. Members of the Committee present included: J. Watts Lipscomb, Forest Park, Chairman; M. B. Lumpkin, Dalton, Vice Chairman; Fred C. Smith, Valdosta; and Fred H. Simonton, Chickamauga.

Second Vice-President

Fleming L. Jolley, M.D., *Atlanta*

Thank you for having made it possible for me to serve as your Second Vice-President of this Association. Observing the Executive Committee in action has been a privilege of this office. The Executive Committee members are to be congratulated for their dedicated service on behalf of the Medical Association of Georgia.

The increasing complexities of state, federal, and local governmental programs affecting our professional practice seem overwhelming. Whether the physician wishes to be involved or not, the public (as a majority) has already demanded their personal care be so governed.

A mechanism to identify this continually changing program, prevent overlapping of responsibilities and manpower, but foremost to keep the individual physicians collectively informed is warranted.

The House of Delegates appears obligated to study and formulate methodology for such a system if any semblance of free enterprise is to be retained by the medical profession.

This in no way should deter individual physicians participating on behalf of the organization as has so magnificently been done but augment their efforts.

REFERENCE COMMITTEE RECOMMENDATION—Your Reference Committee calls to the attention of the House that no recommendation is made as this report has been in fact acted upon by Council. The Committee recommends approval with commendation.

HOUSE OF DELEGATES ACTION—Adopted the Reference Committee recommendation as presented.

Council of MAG

F. G. Eldridge, M.D., *Chairman*

The following report, submitted as a result of the actions of Council, presents a review of actions of Council during the past year and is not necessarily in chronological order.

1. The Medical Association of Georgia and the City of Atlanta are indebted to Dr. J. W. Chambers, Senior AMA Delegate from Georgia, who spearheaded the drive that resulted in the acceptance of Atlanta as the site of the Clinical Convention of the American Medical Association in the year 1972. Dr. Chambers was assisted by the members of the Georgia Delegation and the Atlanta Convention Bureau, and this will mark the first time in the 20th Century that the AMA has held its convention in Georgia.

2. We are happy to report that the Medical Association of Georgia was successful in retaining our contract with the Department of Defense for the administration of the Military Medicare Program. The Association was advised during the summer that the current contract would not be renewed upon expiration. The reason given by the CHAMPUS Office in Denver, the operational headquarters for this program, was to the effect that General Counsel to the Department of Defense had ruled that a conflict of interest exists in cases where State Medical Associations were administering the Military Medicare Program.

As a result of the excellent efforts of the Headquarters Staff and Legal Counsel to the MAG, the conflict of interest was completely repudiated and the Medical Association of Georgia will continue to administer this program in the efficient manner that has always reflected credit on the entire profession of Georgia.

3. Appointed a Special Finance Committee (see Committee report).

4. Approved the recommendations of the President of MAG to cooperate fully with the Georgia State Board of Health to improve and expand Health Programs.

5. Approved the Second Vice President's recommendations to appoint Physicians, whenever possible, to policy making committees of Federal and State medical programs.

6. Requested, and empowered the President of the Medical Association of Georgia to appoint members of a Central Billing System Study Committee (see Supplemental Report of Council on Central Billing).

7. Approved the President of the Medical Association's recommendations to establish closer liaison and cooperation with the State Board of Health. As a result, and, following contact with the members of the State Board of Health, a plan was instituted by which a member of the State Board of Health would visit with Council on a regular basis, and in turn the Medical Association of Georgia would send a representative to meet with the Board of Health at their regular meetings. This has resulted in harmony and cooperation.

8. Appointed a permanent Hospital Clinical Charts Committee in accordance with resolution No. 8 MAG Annual Meeting of 1967.

9. Approved a request for full cooperation in the compilation of the History of Medicine in Georgia which is undertaken by the University of Georgia History Department.

10. Following consultation and discussion with members of the State Board of Health, Council appointed a Special Committee to outline a request to the Georgia State Board of Health regarding method of payment for services rendered to Medicaid recipients as follows:

> "The Council of the Medical Association of Georgia recommends that implementation of Title 19 be in a manner which recognizes the physician's right to bill directly all patients, including Title 19 patients, and allows the physician or his patient to be reimbursed his usual, customary and reasonable fee for his professional services."

The Council also requested that if at all possible, some type of device such as credit card, stamping type card, etc. be instituted and this card contain all necessary details of identification, serial numbers, birth dates, addresses, etc. be supplied recipients which could be used by physicians' secretarial and office personnel to reduce the amount of time in preparation of records and billing as well as to improve inclusion of pertinent material necessary for such records.

11. Approved a Statewide Measles Immunization Program to be administered by the Board of Health in cooperation with civic groups.

12. Approved a request, and appointed a committee, to study recommendations submitted by Fulton County Medical Society with reference to employment of a full-time physician to represent medicine in working on and coordination with State and Federal Governmental Agencies on matters pertaining to health programs.

At the March 1968 meeting of Council the report of the Ad Hoc Committee on Employment of Physician For Health Programs was received. Permit me to quote from that report:

> "That increasing complexities of the state and federal programs related to patient care will continue is also appreciated. Placement of key physicians to important positions within the authorized programs must be encouraged. Competent leadership can thereby protect the interests of organized medicine and the individual physician."
>
> "Denial of the existence of such programs and failure to offer leadership will be our loss."
>
> "Cost of additional staff to support such a program appears prohibitive at this time. The committee recommends that although such a position is not feasible at this time reappraisal be periodically made as such need may be realized."

RECOMMENDATION

Council approved this report and accordingly recommends that the House of Delegates sustain this position with the view that the feasibility of the employment of a full-time physician for this purpose will be reviewed periodically.

13. At the meetings of Council in September and December 1967, approval was given authorizing informal, non-binding, exploratory talks with the Board of Medical Examiners on the question of resolving the licensure differences between Doctors of Medicine and Doctors of Osteopathy. Such talks ultimately involved the Osteopaths themselves in a series of meetings conducted by, and at, the Board of Medical Examiners Office.

It should be remembered that events at the federal level, principally Medicare and Medicaid, made urgent

these meetings and efforts to resolve the perennial conflicts, and satisfy the need for more orderly implementation of these federal programs. Nothing conclusive can be reported at this time, however, it is anticipated that a supplemental report of Council will be submitted on this important matter for the consideration of the House of Delegates pending further developments.

14. Amendments to the Constitution and Bylaws were submitted to Council at its March 1968 meeting by the Committee on Constitution and Bylaws pursuant to Chapter IX, Section 6 of the Bylaws.

The Council reviewed each of the proposed amendments and concurs in the adoption of each as proposed by the Committee.

15. Council voted to reaffirm MAG policy of encouraging physicians to seek opportunities to serve on the governing boards of hospitals.

REFERENCE COMMITTEE RECOMMENDATION—Your Committee would like to amend item 15 by adding after "hospitals" the following statement: "and any other organization wherein their talents, training and experience can be used to further the aims of the medical profession." The paragraph would then read: "Council voted to reaffirm MAG policy of encouraging physicians to seek opportunities to serve on the governing boards of hospitals and any other organization wherein their talents, training and experience can be used to further the aims of the medical profession." The Committee recommends adoption of this report as amended with commendation.

HOUSE OF DELEGATES ACTION—Adopted the Reference Committee recommendation as presented.

Sixth District Councilor

CHARLES T. COWART, M.D., *LaGrange*

This Councilor has attended all meetings of Council. He has regularly forwarded the summary sheets of Council meetings and Executive Committee meetings. He has served on four MAG committees, being chairman of three.

I have enjoyed my years serving as Vice-Councilor and Councilor. I have decided to retire from Council in favor of a younger man. Dr. Earnest Proctor of Newnan is the in-coming Councilor and Dr. Norman Gardner of Thomaston is the in-coming Vice-Councilor. They are both young, energetic, and interested in the Association.

RECOMMENDATIONS

1. That an explanatory brochure on the Medical Association of Georgia Foundation be prepared immediately and forwarded to every member of the Association and to any and all interested parties. I would like to see a full-page ad in every issue of the *Journal of the Medical Association of Georgia* reminding the members of the Foundation, encouraging County and District Societies to contribute, and including a statement of the financial condition of the Foundation. I recommend that contributions to the Foundation become an annual budgeted item of the Medical Association of Georgia, if possible.

2. I recommend that a section be included in the annual *Roster* which will contain:

(1) The entire Constitution and By-Laws of the Medical Association of Georgia.

(2) Description of the aim, purposes, duties, and available services of all standing committees of the Association.

3. I recommend that Council investigate the need and desirability of employing a second Field Service Representative, and dividing the state into two equal territories, giving one territory to each of the two men. Georgia is geographically a large state with 3,000 members, and many county and district societies.

4. I recommend that the House of Delegates consider the need and value of the Association's sponsoring an educational program for the nurses of Georgia, to be held at the same time and in conjunction with the Annual Session. This is a successful program with the American College of Surgeons at some of their Sectional meetings. If this recommendation is approved, it might be turned over to the Committee on Paramedical Study and the Annual Session Committee.

Counties and Secretaries	Members December 31, 1967 MAG	Members December 31, 1967 AMA Dues Paying Only	Members December 31, 1966 MAG	Members December 31, 1966 AMA Dues Paying Only
Clayton-Fayette				
F. A. Sams, Jr.				
Fayetteville	9	8	9	9
Coweta				
Robert Jarrell				
Newnan	22	16	20	15
Lamar				
S. B. Traylor				
Barnesville	4	4	4	4
Meriwether-Harris				
J. E. Collins				
Manchester	14	12	14	11
Spalding				
Kenneth Reynolds				
Griffin	42	37	43	39
Troup				
Edward A. Prieto				
LaGrange	40	33	39	33
Upson				
L. L. Allen				
Thomaston	18	15	18	15
	149	125	147	126

REFERENCE COMMITTEE RECOMMENDATION—The Committee would call to the attention of the House that Dr. Cowart intends to retire from Council. The Committee would like to amend recommendation No. 1 by adding the word "possible" between the words "every" and "issue" so that the recommendation will read: "I would like to see a full page ad in every possible issue of the *Journal of the Medical Association of Georgia* reminding the members of the Foundation, encouraging County and District Societies to contribute, and including a statement of the financial condition of the Foundation." Your Committee recommends that in recommendation No. 2 the words "upon approval of Council" be inserted between "recommend that" and "a section" so that recommendation No. 2 will then read: "I recommend that upon approval of Council a section be included in the annual Roster which will contain:" etc. Your Reference Committee further recommends that the words "instruct the Council to request the proper committee to" be inserted between the words "delegates" and "consider" so that recommendation No. 4

will read: "I recommend that the House of Delegates instruct the Council to request the proper committee to consider the need and value of the Association's sponsoring an educational program for the nurses of Georgia, to be held at the same time and in conjunction with the Annual Session." The Committee recommends approval of the report as amended with commendation and requests special commendation of the House for Dr. Cowart for his long and faithful service as a member of Council.

HOUSE OF DELEGATES ACTION—Adopted the Reference Committee recommendation as presented.

Eighth District Councilor

F. G. Eldridge, M.D., *Valdosta*

The Eighth District Councilor attended all meetings of Council during the past year.

Attendance at District Medical Meetings in the Eighth District has been poor for several years. Midweek, weekend, and so-called permanent location meeting places have been attempted without improvement of attendance.

This year, on April 6, 1968, an effort to attract members to attend the meeting was formulated around the joint meeting of the Eighth District Medical Society with the South Georgia Medical Society as host, and a Medical Seminar Type program with distinguished speakers from the University of Florida Medical School, the University of Colorado Medical School, and the University of Mississippi Medical Center.

It is hoped that this plan succeeds in improving attendance at District medical meetings.

Counties and Secretaries	Members December 31, 1967 MAG	Members December 31, 1967 AMA Dues Paying Only	Members December 31, 1966 MAG	Members December 31, 1966 AMA Dues Paying Only
Altamaha				
H. L. Morgan				
Baxley	6	6	7	6
Ben Hill-Irwin				
Roy Johnson, Jr.				
Fitzgerald	7	7	7	7
Coffee				
Richard L. Benson				
Douglas	10	8	11	7
Camden-Charlton				
H. H. Robinson				
Kingsland	10	7	10	9
Glynn				
E. A. Mayo				
Brunswick	49	46	53	49
Ocmulgee				
C. M. Johnson				
Eastman	15	11	16	10
South Georgia				
Richard L. Nutt				
Valdosta	62	48	61	53
Telfair				
D. B. McRae				
McRae	6	5	6	5
Ware				
J. W. Bickerstaff				
Waycross	43	41	41	39
Wayne				
E. L. Harrell				
Jesup	9	9	9	9
	217	188	221	194

REFERENCE COMMITTEE RECOMMENDATION—Your Reference Committee recommends approval with commendation.

HOUSE OF DELEGATES ACTION—Adopted the Reference Committee recommendation as presented.

Fulton County Medical Society Councilors

Linton H. Bishop, Jr., M.D., *Atlanta*
Fleming Jolley, M.D., *Atlanta*
Harold Harrison, M.D., *Atlanta*

The Councilors of the Fulton County Medical Society this year have attempted to effectively represent our component medical society during Council activities. We have also actively tried to represent the Council at our local society functions. One of the councilors has made a report to the Board of Trustees and to the Society in person after each meeting of the Council. We have fully reported to the Council Fulton County Medical Society's activities with the Office of Economic Opportunity and have reported our attempt to show that medical care for all people can best be delivered through the mechanism of the private practitioner on a usual and customary fee basis. With the multiple government programs mushrooming, our society sees a need for a specialist in government programs who will keep tabs on the possibilities and probabilities of future physician involvement and will be conversant with all features of government and third party problems related to medicine so that the Medical Association of Georgia can keep abreast and ahead of these problems.

RECOMMENDATION

That the Association establish a committee to consider the necessity and the advisability of such a staff physician. Our legislative committee and staff spent a considerable amount of time and effort helping with the problems of medicine as related to our laws during the past session of the general assembly. We brought to the attention of Council at the direction of our Society the problem of third party payment to large institutions for professional services and this is being studied by a special committee appointed by the President.

Participation of our councilors in the affairs of the Medical Association of Georgia during this year has been gratifying and encouraging. We have had full representation at all meetings.

Counties and Secretaries	Members December 31, 1967 MAG	Members December 31, 1967 AMA Dues Paying Only	Members December 31, 1966 MAG	Members December 31, 1966 AMA Dues Paying Only
Fulton				
F. W. Dowda				
Atlanta	1099	904	1071	880

REFERENCE COMMITTEE RECOMMENDATION—The Committee would call to the attention of the House that the recommendations of the Councilors from Fulton County have already been acted upon as

reported in the report of Council and recommends approval of the report with commendation.

HOUSE OF DELEGATES ACTION—Adopted the Reference Committee recommendation as presented.

Traffic Safety

FLEMING L. JOLLEY, M.D., *Chairman*

The Committee on Traffic Safety thanks those county medical societies that have established committees related to problems of Emergency Medical Services.

Your committee hopes that county medical societies shall consider more active roles in encouraging and assisting local Red Cross Chapters in teaching basic first aid and advanced first aid as a public service.

The medical societies should take further leadership roles in community planning for improved Emergency Medical Services, not only through first aid and rescue training, but identifying local needs in both rural and urban areas for improving transportation, as well as communication between emergency vehicles and emergency care facilities.

REFERENCE COMMITTEE RECOMMENDATION—Your Committee would like to substitute the word "recommend" for "hopes" in the second paragraph and delete the word "shall." The second paragraph would then read as follows: "Your committee recommends that county medical societies consider more active roles in encouraging and assisting local Red Cross Chapters in teaching basic first aid and advanced first aid as a public service." The third paragraph should start with the words: "It is further recommended that" so that the third paragraph would then read: "It is further recommended that the medical societies should take further leadership roles in community planning for improved Emergency Medical Services, not only through first aid and rescue training, but identifying local needs in both rural and urban areas for improving transportation, as well as communication between emergency vehicles and emergency care facilities." Your Committee recommends adoption of the report as amended with commendation.

HOUSE OF DELEGATES ACTION—Adopted the Reference Committee recommendation as presented.

AMA-ERF

BRASWELL E. COLLINS, M.D., *Chairman*

Your committee has been more active and productive than any known year before.

In December 1967, Georgia physicians and friends contributed $1,483 to AMA-ERF. Your committee thanks these contributors sincerely.

Mrs. William J. Pendergrast, 3398 Briarcliff Road, Atlanta, 30329, is State Chairman for the MAG Auxiliary. She and her committees have proposed several projects for fund raising throughout the state. An exhibit at the MAG meeting in Augusta in May will demonstrate the needs of AMA-ERF and how they can be met.

Your committee requests the House of Delegates to encourage the MAG Auxiliary to make AMA-ERF a major activity.

REFERENCE COMMITTEE RECOMMENDATION—Your Reference Committee recommends that the last paragraph be amended to read as follows: "Your committee requests the House of Delegates to commend the MAG Auxiliary for its activities in this area and encourage its continued interest in the AMA-ERF." Your Reference Committee recommends approval as amended with commendation.

HOUSE OF DELEGATES ACTION—Adopted the Reference Committee recommendation as presented.

Disaster Medical Care

VIRGIL B. WILLIAMS, M.D., *Chairman*

The chairman has been in correspondence with committee members as the need arose.

Liaison with State Civil Defense authorities has been maintained. We have obtained a renewal of a previous pledge to furnish transportation and housing for medical personnel at major disaster scenes.

Close study has been made of all communications emanating from AMA in reference to meetings concerning disaster medical care. Since the principal meeting was held in San Francisco this year, no committee member attended.

The committee has been ready at all times to assist societies in planning Disaster Medical Care Programs. Information concerning Disaster Medical Care Programs has been distributed to county societies requesting such.

REFERENCE COMMITTEE RECOMMENDATION—Your Committee recommends approval with commendation.

HOUSE OF DELEGATES ACTION—Adopted the Reference Committee recommendation as presented.

Hospital Activities

CHARLES T. COWART, M.D., *Chairman*

The Hospital Activities Committee has not been busy this year. No problems have been presented for consideration. Our aims and duties were approved by the House of Delegates last year. We were to publish and distribute a brochure about the committee, but deferred it because we understood that the MAG was planning to publish a more complete booklet about the function and responsibilities of all association committees. This has not materialized, so we plan to publish and distribute our brochure this year. In my report as Sixth District Councilor, I have recommended that the aims, purposes, and duties of all standing committees of the Association be published in the Roster.

The chairman of the committee attended a two-day workshop on "The Doctor and His Hospital" in Chicago, Illinois March 7-8, 1968. This workshop was presented by The Institute of Medicine of Chicago.

REFERENCE COMMITTEE RECOMMENDATION—Your Committee recommends approval of the report with commendation.

HOUSE OF DELEGATES ACTION—Adopted the Reference Committee recommendation as presented.

Medical Education Committee

J. RHODES HAVERTY, M.D., *Chairman*

This year has been a relatively quiet year so far for this committee. It has met twice, once in November and once in December.

There are several points considered by this committee, which were referred to it by the 1967 MAG House of Delegates:

1. We are working with the two medical schools on

many subjects, including Health Care Manpower. The Deans of the medical schools are on the Medical Education Committee.

2. We decided not to conduct a survey of Health Care Manpower, feeling the MAG had neither the finances nor the personnel to do so. However, we agreed to maintain our interest in such a survey should other groups wish to plan one.

3. The usual biannual Conference on Medical Education will be planned for 1969 during future meetings of the committee.

4. The Chairman will act as liaison between the MAG and the medical schools by meetings with the Deans of the two schools.

5. Increasing the output of paramedical personnel concerns this committee but is more immediately appropriate to the Paramedical Study Committee.

6. A third medical school feasibility study is being planned by the Georgia Science and Technology Commission, which will be assisted by the MAG.

It has become obvious that there are many overlapping areas of involvement and situations for joint concern between the Committee on Medical Education and several other bodies, including the Georgia Regional Medical Program, the Georgia Science and Technology Commission, the University System Board of Regents, and several other of our own MAG committees. In some of these inter-relationships occasional conflicts arise, and must be dealt with before progress can be made. This committee will continue to try to act as a clearing house for the Medical Association of Georgia in ALL matters pertaining to medical education.

This committee was asked to provide and has arranged much of the morning program for the first session of the 114th Annual Session of the MAG. The committee hopes the program will prove of interest and worth to the members of the Association.

RECOMMENDATION

The committee would like to continue the biannual Medical Education Conference in a similar manner to those held in 1965 and 1967 at Callaway Gardens. It would like to request the Finance Committee to budget again approximately $1,200 for this committee for fiscal 1969.

REFERENCE COMMITTEE RECOMMENDATION—Your Committee recommends approval with commendation.

HOUSE OF DELEGATES ACTION—Adopted the Reference Committee recommendation as presented.

Medicine and Religion

J. T. Hogan, Jr., M.D., *Chairman*

The Committee on Medicine and Religion met at Medical Association of Georgia Headquarters on January 19, 1967. Those present were John Rabun, M.D., Savannah, William Hopkins, M.D., and Joseph Cruise, M.D., Atlanta, Curtis Hames, M.D., Claxton, Mr. Robert Coons, Chicago AMA Department of Medicine and Religion, Miss Merrilie Davis, MAG staff member, and the State Committee Chairman, J. T. Hogan, Jr., M.D., Macon.

The meeting was opened by Dr. Hogan, who stated the purposes of the MAG Committee on Medicine and Religion. These were further elaborated upon by Mr. Robert Coons who also pointed out what type programs were available to state and county medical societies on this subject.

Members of the state committee voted to have a booth at the MAG annual meeting. Mr. Coons agreed to come down from Chicago and help the state committee members man the booth. This came to pass but unfortunately our booth did not seem to create much interest among those attending the convention.

All county societies were contacted by mail and asked to elect a representative to the state committee on Medicine and Religion if they did not already have one. These societies were also asked to advise the state committee what progress had been made on the local level regarding society problems and projects on Medicine and Religion.

On January 11, 1968, your state committee chairman met again with Mr. Robert Coons of Chicago to work out a statewide program this year on Medicine and Religion.

In view of the fact that Reverend Dr. Paul McClean, Director of AMA Department of Medicine and Religion conducted a southeastern workshop in Atlanta this Spring, I requested that all of our local society chairmen be allowed to attend this workshop too. This, of course, was granted by the AMA Department of Medicine and Religion. We had a great and enthusiastic attendence at this conclave. All local county society committee chairmen were invited.

REFERENCE COMMITTEE RECOMMENDATION—Your Committee recommends approval of the report with commendation.

HOUSE OF DELEGATES ACTION—Adopted the Reference Committee recommendation as presented.

Mental Health

Julius T. Johnson, M.D., *Chairman*

This committee has had four meetings all of which have been well attended.

Since this committee had no activity during 1966 and 1967, but had been extremely active and productive from 1962-1966, the actions of these past committees were reviewed in detail. The majority of the work of these past committees was concerned with the development of the Georgia Mental Health Plan with special emphasis on supporting the decentralization of (Milledgeville) Central State Hospital, the development Regional State Hospitals, and guidelines for the development of Comprehensive Community Mental Health Centers—all of which is now history.

In view of the accomplishments in the field of Mental Health in the State of Georgia in recent years, it was felt that the Purpose and Goals of this Committee should be revised as follows:

"To act in an advisory capacity to the Medical Association of Georgia in matters pertaining to mental health and mental illness, and to attempt to keep the Medical Association of Georgia informed as to relevant developments in this area.

"To provide leadership in the field of mental health and mental illness in promoting better patient care, and in the prevention of mental disorders.

"To act in a capacity for stimulating interest and further informing both the Medical Association of Georgia members, and to a lesser extent, lay individuals, concerning mental health and mental illness."

The past work of this Committee and the MAG concerning the development of a statewide indigency formula was reviewed. Apparently it has been accepted by everyone concerned, that a statewide formula was probably not possible. Currently, the determination of financial eligibility and indigency is being handled at a local level by the local health officer and the local medical society and that it is probably too early to tell how well this will work out and how well the local communities wil accept this. The Committee is to be furnished feedback from the various programs that are now operational on this basis.

The Committee reviewed the Mental Health Kit prepared by the Auxiliary Mental Health Chairman and it was agreed that she should be commended for her efforts and that this material should be widely disseminated. A very extensive scrapbook depicting the history of "Mental Health in Georgia," which had been prepared by a previous Auxiliary Mental Health Chairman was reviewed. The committee felt the Auxiliary was to be highly commended for their efforts and recommended that the possibility of publication be pursued.

The Committee has reviewed legislation concerning Mental Health and highly endorses this legislation.

Since the Georgia Mental Health Plan is in the stage of implementation, the progress to date and problems involved have been reviewed in detail by the Committee. The Committee commends the Mental Health Division for their splendid effort to date. Apparently the biggest problem felt by the Mental Health Division at this time is physician apathy to the implementation of the program.

A major portion of the work of the Committee has been an effort to attempt to determine areas of interest and the best method of accomplishing programs for the non-psychiatric physician. Efforts in this area by the Medical College of Georgia, Emory University, MAG, the Georgia Psychiatric Association, and the Mental Health Division were reviewed. It is noted with interest that the AMA has a Psychiatric Consultant, Dr. Joseph Baker, who could probably be of help to us. Dr. Baker is to be invited to a future meeting. A Subcommittee on Medical Education was appointed which recommended that MAG do a survey of local medical societies to determine: 1) if the Society has a local mental health committee or someone who will function in this area, 2) did the Society offer a mental health program during the past two years, 3) does the Society have an interest in presenting a mental health program. This survey was approved by MAG Executive Committee, and thirty of seventy local societies responded as follows:

Item one above: yes—19; no—21

Item two above: yes—5; no—23; unanswered—2

Item three above: yes—14; no—11; unanswered—5

Once the survey is completed and evaluated, the Committee will continue with further planning concerning programs for the non-psychiatric physician.

The Fourteenth Annual Conference of State Medical Society Mental Health Representatives was held in Chicago, Illinois, March 15 and 16, 1968, and was attended by two of our Committee members.

The Committee continues to have a keen interest in the improvement and expansion of psychiatric treatment facilities in both the public and private sectors.

At the time, there are no recommendations for consideration by the House.

REFERENCE COMMITTEE RECOMMENDATION—Your Reference Committee would call to the attention of the House the fact that Supplemental Report No. 5 is an addendum to this report. Your Committee recommends adoption of this report with commendation.

HOUSE OF DELEGATES ACTION—Adopted the Reference Committee recommendation as presented.

Public Service

ROBERT GOTTSCHALK, M.D., *Chairman*

The Committee again sponsored the Annual Leadership Conference which was held this year on February 3 and 4 at the Riviera Motor Hotel, Atlanta. This was the 10th such Conference and it appears that interest is growing.

The Committee wishes to publish for distribution to new members an informational booklet designed to give the physician in one volume certain factual material on the topics of ethics, narcotics, dues, insurance plans, licensure, birth and death certificates, sterilization and the like. It is the Committee's opinion that such a booklet would prove to be invaluable to the practicing physician.

REFERENCE COMMITTEE RECOMMENDATION—Your Committee would suggest amending the first sentence of the second paragraph by inserting after the word "wishes" the phrase "with approval of Council." The paragraph would then read: "The Committee wishes, with approval of Council, to publish for distribution to new members an informational booklet designed to give the physician in one volume certain factual materials on the topics of ethics, narcotics, dues, insurance plans, licensure, birth and death certificates, sterilization and the like." Your Committee recommends adoption of the report as amended with commendation.

HOUSE OF DELEGATES ACTION—Adopted the Reference Committee recommendation as presented.

Rural Health

THOMAS N. LUMSDEN, M.D., *Chairman*

In 1967, the Rural Health Committee of the Medical Association again emphasized in its activities programs to bring together groups and agencies which deal in the various fields relating to health programs for rural Georgians.

In keeping with this aim, representatives from the State Department of Public Health, Georgia Dental Association, Georgia Veterinarians' Association, Georgia Congress of Parents and Teachers Association, Georgia Press Association, Georgia Farm Bureau and Cooperative Extension Service of the University of Georgia were asked to cooperate in forming an Advisory Council to the Rural Health Committee. These groups cooperated and a council was formed. One general meeting of this Advisory Council was held, at which time plans for the Third Annual Rural Health Conference were discussed.

The Third Annual Rural Health Conference was held at Rock Eagle 4-H Conference Grounds on October 13 and 14. Approximately 120 rural community leaders were in attendance for this meeting. Georgia Kiwanis Clubs participated in the promotion of this Conference

and the Governor of Georgia Kiwanis Clubs attended the Conference. The program consisted of the following:

"THIRD ANNUAL GEORGIA
RURAL HEALTH CONFERENCE"

Co-Sponsored by the Medical Association of Georgia and the Georgia Farm Bureau Federation in cooperation with the Cooperative Extension Service of the University of Georgia.

October 20-21, 1967
Rock Eagle State 4-H Club Center
Eatonton, Georgia

PROGRAM

FRIDAY AFTERNOON SESSION—
UNION BAG BUILDING
October 20, 1967

11:30 A.M. *Conference Registration*

12:00 NOON *Conference Luncheon—Dining Hall*

1:15 P.M. *Call to Order and Invocation*
Thomas N. Lumsden, M.D., Presiding
Chairman, Committee on Rural Health
Medical Association of Georgia
Clarkesville
Mr. Cecil Johnson, Director
Rock Eagle 4-H Club Center
Eatonton

1:20 P.M. *Welcome*
Mr. William H. Lanier, President
Georgia Farm Bureau Federation
Macon

1:35 P.M. *Key Note Address—"Planning for Comprehensive Health Services"*
John Venable, M.D., Director
Georgia Department of Public Health
Atlanta

2:00 P.M. *"Severe Reaction to Stinging Insects"*
Carl C. Jones, Jr., M.D.
Atlanta

2:30 P.M. *"A Dollar's Worth of Service for Each Dime Invested In the March of Dimes"*
Mr. Dabney M. Coddington, Jr., Field Representative
The National Foundation—March of Dimes
Atlanta

3:00 P.M. *Intermission—Coffee and Rolls*

3:15 P.M. *"Venereal Disease Education Programs for Teenagers"*
Mr. Mike Morgan, Public Health Advisor
National Communicable Disease Center
Atlanta

3:45 P.M. *"What the New Heart, Cancer and Stroke Program Means To You"*
J. W. Chambers, M.D., Program Director
Georgia Regional Medical Program
LaGrange

4:15 P.M. *Questions and Answers*

RECESS

6:00 P.M. *Conference Dinner With Entertainment—Dining Hall*
Entertainment by the Kitchen Kuties

SATURDAY MORNING SESSION—
UNION BAG BUILDING
October 21, 1967

7:30 A.M. *Conference Breakfast—Dining Hall*

8:30 A.M. *Call to Order*
Thomas N. Lumsden, M.D., Presiding

"Award Winning Georgia 4-H Health Demonstration Project"
Miss Penny Gaultney
4-H Health Winner
Roberta

9:00 A.M. *"What's New in Traffic Safety Projects for Georgia"*
Mrs. Dean Dickens, Defensive Driver Education Program
Atlanta Traffic Safety Council
Atlanta
Mr. Ben Jordan, Georgia State Coordinator
National Highway Safety Bureau
Atlanta

10:00 A.M. *Intermission—Coffee and Rolls*

10:15 A.M. *"Teenage Nutrition"*
Mrs. Rita H. Waters
Extension Home Economist—Nutritionist
Athens
Miss Dee Harden
Girls Vice President
State 4-H Council
Zebulon

10:45 A.M. *"Medical Self Help—A Must for Every Family"*
Mrs. Judy Edwards
Special Agent—Civil Defense Extension Service
Athens

11:15 A.M. *"Challenge To Action—A Summary by Key Listeners"*
Mrs. J. B. Green, President
Georgia Extension Home Economics Council
Moultrie
Dr. J. J. Lancaster, Head
Extension Education Department
Athens
Mrs. Andy Rape, President
Georgia Farm Bureau Women
McDonough

11:45 A.M. *Final Conference Luncheon—Dining Hall*

The Medical Association of Georgia was represented at the National Rural Health Conference held at Charlotte, North Carolina. Georgia Farm Bureau and Farm Bureau Women and Cooperative Extension Department were also represented. Following this meeting, an invitation was extended to the Council on Rural Health of the American Medical Association for the 1971 National Rural Health Conference to be held in Atlanta. This invitation was accepted.

The Rural Health Committee has worked closely with other committees of the Medical Association of Georgia. Time was provided to the Traffic Safety Committee for a presentation of part of the Traffic Safety Committee's program of Education and Accident Prevention in Georgia. The Rural Health Council was asked to provide a member for the Education Committee of the Medical Association of Georgia. This was done.

The Rural Health Committee has a pilot project in operation in one county society in cooperation with the county Farm Bureau which it is felt is a worthwhile program. In this project, First Aid courses have been taught by members of the county medical society, using texts purchased by Farm Bureau funds. These courses are aimed at local firemen, policemen, Sheriff's Department and local ambulance drivers. Twenty certificates have been awarded and an additional class is to be held. Plastic splints, airways and resuscitator bags were purchased by the medical society and presented to the various participating rescue units and emergency

squads. In addition, a county-wide Highway Safety Committee sponsored by the medical society and Farm Bureau has been organized and courses in defensive driving are being offered.

This joint activity is described in some detail because it is felt that, as noted above, this can be a pilot project which can well be used as a model by other interested societies.

It is therefore a recommendation of this Committee, that closer cooperation be established between component societies and local Farm Bureau organizations and that component societies interest themselves in programs of mutual interest and benefit to members of Farm Bureau, Home Demonstration Clubs, rural PTA's and similar groups. It is recommended that local societies make themselves available to provide speakers for programs, to obtain resource supplies and educational material for such groups. Appointment of a Rural Health Chairman by each component society has been previously recommended. This recommendation is reiterated. It is suggested that in the smaller societies that one committee combine responsibilities for both Highway Safety and Rural Health.

REFERENCE COMMITTEE RECOMMENDATION—Your Committee recommends that the last two sentences be deleted and in lieu thereof the following inserted: "It is recommended that Rural Health be incorporated into Traffic Safety Committee of component county societies where applicable." Your Committee recommends adoption of the report as amended with commendation.

HOUSE OF DELEGATES ACTION—Adopted the Reference Committee recommendation as presented.

Supplemental Report of the Mental Health Committee No. 5

DRUG ABUSE INVESTIGATION AND MENTAL HEALTH PROGRAMS

JULIUS T. JOHNSON, M.D., *Chairman*

At the March 24, 1968, meeting, three of our members stated that they had attended the 14th Annual Conference of State Medical Society Mental Health Representatives, held in Chicago, Illinois, March 15-16, 1968, the theme of the program being "Drug Abuse in the 'Now' Generation." The problem of drug abuse in the state of Georgia was discussed in some detail, along with the report of the meeting, and the following recommendation was made:

RECOMMENDATION:

That the Medical Association of Georgia and the State Department of Public Health investigate the extent and percentage of drug abuse in the state, and also to determine what is being done statewide to educate students on drug abuse.

The Subcommittee on Continuing Education made the following recommendations which were approved by the Mental Health Committee:

RECOMMENDATION:

1. The societies that have expressed interest in mental health programs should be contacted to explore further the kind of program they would like to present. Mr. Wallace of MAG volunteered to take this responsibility.

2. The MAG should contact the Georgia Psychiatric Association for availability of speakers and consultants.

3. A list of possible program items as well as speakers' favorite topics, should be prepared by a group that will include representative individuals from MAG and GPA.

4. MAG should contact the local societies at least annually concerning available program materials and speakers, as well as their needs in this area.

5. Mental Health Committee should consider the relationship between medical societies and local mental health associations. It was felt that physician participation in community activities as such, should be encouraged.

6. In developing mental health programs for medical societies and hospital staff meetings, continuity of effort is seen as a crucial factor. The Subcommittee feels that such continuity can only be provided through the active involvement of the Executive Secretary of MAG and his staff in the promotion and implementation of this educational program. MAG also should be responsible for coordinating the activities and planning of groups such as the MAG Mental Health Committee, Mental Health Committee of the Georgia Academy of General Practice, and the MAG Committee on Education.

REFERENCE COMMITTEE RECOMMENDATION—Your Committee recommends that the phrase "a group" in line 20 be deleted and insert the phrase "the Mental Health Committee" so that it will read: "A list of possible program items as well as speakers' favorite topics, would be prepared by the Mental Health Committee that will include representative individuals from MAG and GPA." Your Committee further recommends that the phrase "Mental Health" be inserted between the word "community" and "activities" on line 27. The recommendation will then read: "It was felt that physician participation in community mental health activities as such, should be encouraged." Your Committee recommends adoption of the report as amended with commendation.

HOUSE OF DELEGATES ACTION—Adopted the Reference Committee recommendation as presented.

Resolution No. 7

SURVEY OF THE PRACTICING PHYSICIANS OF GEORGIA

W. M. WATKINS, M.D.
For Laurens County Medical Society

WHEREAS, an adequate Survey of the practicing Physicians of Georgia has never been made, and

WHEREAS, it is necessary that such a survey be made before it can be determined how many graduates of Georgia Medical Colleges are needed to adequately give Medical Care to the people of Georgia, and

WHEREAS, the Board of Regents of the University System, Emory University and the Medical College of Georgia needs this information for future planning, and

WHEREAS, such information is necessary in planning for the size of the admission classes of the Medical Colleges, and for the Board of Regents to begin to consider the development of a third Medical College.

NOW THEREFORE BE IT RESOLVED, that the facilities of the Headquarters Staff of the Medical As-

sociation of Georgia be used to make an adequate Survey of Georgia Physicians, and that the results of the survey be made available to the Board of Regents, the Deans of the respective Medical Colleges, and to the Committee on Medical Education of the MAG and that it be reported to the next session of the House of Delegates.

REFERENCE COMMITTEE RECOMMENDATION—Because it was difficult for your Reference Committee to interpret the intent of this resolution and because its passage would involve expenditures of MAG funds, it is the recommendation of your Committee that this resolution be referred to Council for clarification and consideration.

HOUSE OF DELEGATES ACTION—Adopted the Reference Committee recommendation as presented.

Resolution No. 10

TO CONTINUE STUDY OF DANGEROUS DRUGS

FULTON COUNTY MEDICAL SOCIETY DELEGATION

WHEREAS, many medications that have potential life saving properties when properly employed, also have hazardous and even life threatening side effects; and

WHEREAS, it is generally recognized that these agents should be reserved for use when the health of the patient would be jeopardized by their being withheld; and

WHEREAS, it is one of the responsibilities of the medical profession to insure the proper use of any therapeutic procedure by its members; and

WHEREAS, the medical profession has always demonstrated its eagerness to maintain the proper use of therapeutic methods.

NOW THEREFORE BE IT RESOLVED, that the MAG continue to study this problem and report its findings to all component societies of the MAG and to the AMA.

REFERENCE COMMITTEE RECOMMENDATION—Your Reference Committee recommends adoption.

HOUSE OF DELEGATES ACTION—Adopted the Reference Committee recommendation as presented.

Chairman Lipscomb then reported that this concluded the report of the Reference Committee No. 4, and moved for the adoption of his report as a whole by the House of Delegates with appreciation to the members of his Committee. This motion was duly seconded and approved.

Report of Reference Committee No. 5

Cecil A. White, Jr., M.D., *Chairman*

(The following reports as presented to this Reference Committee are printed in full with the Reference Committee's recommendations and the action pursuant to them taken by the House of Delegates.)

Chairman White reported to the House that reports and resolutions referred to Reference Committee No. 5 were considered by the Committee which met at 2:30 p.m., Fenwick Room, Augusta Town House Motor Inn, Augusta, on May 6, 1968. Members of the Committee present included: Cecil A. White, Augusta, Chairman; Don Schmidt, Cedartown, Vice Chairman; James H. Manning, Marietta; Irving Hellenga, Toccoa; Albert A. Rayle, Jr., Atlanta; and John B. O'Neal, Elberton.

Secretary

J. RHODES HAVERTY, M.D., *Atlanta*

Your Secretary has carried out his constitutional duties of attending the House of Delegates, Council meetings, and Executive Committee meetings, following up on action taken at these meetings. He also attends special meetings as the MAG representative and various committee meetings when requested.

Correspondence with its appropriate action or referral is attended to almost daily. Policy of the MAG is frequently reiterated in this correspondence, and infrequently established, the latter always with concurrence of other members of the Executive Committee.

MEMBERSHIP

Membership records of the MAG are kept up to date, and annual membership cards mailed out. The year 1967 saw another increase in MAG's membership, as divided below:

Membership	*December 31, 1967*
Active	2992
Affiliate	1
Associate	56
Dues Exempt	319
Honorary	1
Service	61
	3430

HEADQUARTERS OFFICE

Frequent meetings with the staff help me handle the business of the Association, and keep staff informed as to the officers' plans and thoughts.

This year has seen its first change in Executive Secretaries in 15 years, with Mr. Krueger's leaving and Mr. Smith's assuming the position. The change has not been without problems, but because of Mr. Smith's knowledge and ability, it has been a smooth one. New ways of doing things, and new approaches to people and problems will bring adjustments to most of us, but I anticipate no major deviation from established policy.

Mr. Moffett has been elevated to Associate Executive Seeretary, and continues to perform his duties in an admirable way. His particular capabilities as regards legislative matters are inestimable.

Mrs. Wooten continues to prove her worth in always knowing what needs to be done and when, and in efficiently managing the office.

Miss Franklin oversees the considerable financial matters of the Association in her incomparable fashion.

Mr. Wallace's ability and real success in the area of field service has many times over proved the wisdom of this House in recommending his position, and our good fortune in obtaining his services.

Miss Shinnick is another jewel of a find in her position as Managing Editor of the JMAG, and certainly makes the job easier for our Editor, Dr. Woody.

Some changes have been made in the other members

of the office staff, but all personnel are capable, pleasant, and efficient, and should be commended for their often unrecognized worth.

MILITARY MEDICARE (OCHAMPUS)

This past year your Association, through its officers and legal aides, fought a successful battle with the Department of Defense by getting them to rescind an order cancelling the status of the MAG as Administrator of Military Medicare for the State of Georgia. The new contract signed embodies for the first time the concept of usual and customary fees for physicians' charges, both for in-hospital and out-patient visits. Your Secretary continues as the Fiscal Agent for this program, which operates under the very capable hands of Mrs. Joyce Butler. The yearly breakdown in claims received and paid follows:

1967 STATISTICAL REPORT
OCHAMPUS (MILITARY MEDICARE)

Number of Claims	*Annual*	*Per Cent Total*	*Average Per Month*	*Average Per Day*
Received ...	25,244	100	2,104	98
Returned ...	5,572	22	464	24
Rejected ...	812	3	68	3
Adjusted ...	3,520	14	293	13
Adjudicated	176	.7	15	.18
Paid	19,191	76	1,599	74
Total Dollar Amount Paid $1,361,242.97				
Average per claim			53.92*	

GEORGIA REGIONAL MEDICAL PROGRAM

There continues a close liaison with the GRMP and the MAG, which is its applicant. Your Secretary is the Fiscal Agent for this program, and also has been elected Secretary of the Advisory Group.

Personnel, who are actually employees of the MAG, continue to be hired, and numbered 11 persons by the end of 1967. It is anticipated that 1968 will see the addition of as many as 16 new positions filled. All of the present positions and some of the proposed ones work out of the MAG Headquarters Building. The MAG derives a considerable portion of its yearly income from the presence of these employees.

The planning grant budget for 1967 was $240,098.00. The planning grant budget for 1968 is expected to be $547,693.00. An operational grant will be requested in March 1968, to be in effect as of July 1, 1968, and extending for one year. It is estimated to total $2,122,130.00.

MAG FOUNDATION

The MAG Foundation was established during the year. It presently contains about $500.00 and is currently preparing a brochure setting out its aims in order to encourage more contributions and therefore greater use. Its Board of Trustees include Dr. Frank Walker, President; Dr. Rhodes Haverty, Secretary and Treasurer; Dr. Charles Andrews, Dr. Harry Pinson, Dr. Louis Battey, and Dr. John Mauldin.

The brochure to define the duties and functions of the various committees of the MAG is being worked on and hopefully will be completed in 1968. This brings up the subject of the number of our committees, which now total well over 50, and prompts one of my recommendations, listed below.

ASSOCIATION INCOME AND EXPENDITURES

The MAG is financially sound at present, and generally operates efficiently and economically. Income is derived basically from dues, from proceeds from the JMAG, and from other income, much of which is related to programs the Association has undertaken in conjunction with various organizations and agencies. A committee of this House, established last year, has put into effect some money saving and money producing policies. A dues increase is not recommended at this time but it should be noted by this House that an increase in dues is bound to become necessary as increased services and greater involvement by the Association is asked for or expected.

RECOMMENDATIONS

1. I recommend that the House direct the Executive Committee to determine if the total number of committees of the Association could be reduced. Some present committees do not function at all, and others only nominally. There are overlapping areas of involvement of many. It would seem to me that a sizeable reduction would be possible and desirable.

2. I recommend that the Annual Session be given a general overhauling. Our attendance is meager and dwindling. Lack of participation in the business and programs of the Association leads to fragmentation of the profession in all realms, and cannot be good for the physicians or those whom they serve. Sites and programs for the Annual Sessions should be chosen for their general appeal in order to attract the greatest number in attendance. More than the present two year advance notice of sites of selection should be given so that better planning can be accomplished. Commercial exhibits should be discontinued and other means of financing the meeting found. The "fun" aspects of the meetings should be emphasized for both members and their families. The specialty societies should be urged in every way to hold their annual or semi-annual meetings in conjunction with the MAG Annual Session. Other methods of increasing the worth of the meetings to the members should be sought out and employed.

3. The Headquarters Building needs to be expanded to accommodate the increasing personnel, equipment, and activities of the Association. I recommend adding on to our present facilities, utilizing the property we now own. I further recommend that this House empower the Executive Committee to proceed with these plans as soon as possible, reporting to Council as progress is made and as major decisions of expenditures are planned.

4. I would like to recommend to the House, as has been recommended by various officers over the past several years, that it direct the Finance Committee to budget a discretionary fund for use by the Executive Committee. This fund is necessary since expenditures frequently must be made or committed between Council meetings. It is unrealistic to tie the hands of the men empowered to run the Association on a day-to-day basis by limiting their ability to expend monics to once every three months. A sum of $500.00 to $1,000.00 yearly would seem adequate.

REFERENCE COMMITTEE RECOMMENDATION—The Committee approves and commends the Secre-

* *Average per claim reduced from $80.50 in 1966 because these totals include drug claims.*

tary with the following additional recommendations: (1) *With regard to the recommendation regarding MAG committees*, this Committee recommends that the Executive Committee of Council, either by appointment of an additional study committee or within their own organization, review the various committees of MAG with the idea of streamlining overlapping functions and, they along with Council, decrease if needed, the number of committees. This recommendation applies to both Standing and Special Committees. (2) *With regard to the Annual Session recommendation*, this reference committee accepts the recommendation for information and recommends further study. (3) *Regarding the Headquarters Building expansion*, this recommendation was noted, as this item will be discussed in another Reference Committee. However, it is felt that these facilities should be provided as they are needed. (4) *As to the discretionary fund for the Executive Committee*, the committee recommends that a discretionary fund be provided not to exceed $500.00 between meetings of Council and a maximum of $1,000.00 a year, as recommended; the fund not to be accumulative from year to year.

HOUSE OF DELEGATES ACTION—Adopted the Reference Committee recommendation as presented.

Cobb County Councilor

W. C. Mitchell, M.D., *Smyrna*

The Cobb County Medical Society has had a busy year and the membership has increased some 10% over last year. Total membership as of January 1, 1968 numbered 130 and continues to enlarge.

Since the last annual MAG meeting Dr. Remer Clark has been the vice councilor and has been of great help to the Councilor. In addition to the regular meetings held by the society, at which time a scientific program is always presented, several special meetings have been held. These included: (1) joint meeting with the lawyers of the county—to know and have better liaison with the members of the legal profession; (2) a joint meeting with the medical department of Lockheed with primary emphasis on the workings of their insurance program—a visit to look over and be amazed at their new C 5A under assembly was an added attraction of this meeting; (3) another meeting was devoted exclusively to the Medicare program with Mr. Maurice Stevenson of John Hancock and Mr. Dougas Richards of Social Security.

Another yearly planned function of the society is the Medicine and Religion Committee's work with the ministers and lawyers in presenting a symposium on topics of interest and value to all in these groups. This year's subject was "Human Sexuality" and ran a day and a half. The registration was so large that it was held in the auditorium of the Kennesaw Junior College at Kennesaw, Georgia.

The Councilor has attended all the meetings of Council and has made every effort to keep the society informed and up to date in regards to new developments from headquarters level.

The Councilor feels it is an honor and privilege to serve on the Council of the Medical Association of Georgia as representative of the Cobb County Medical Society.

Counties and Secretaries	Members December 31, 1967 MAG	Members December 31, 1967 AMA Dues Paying Only	Members December 31, 1966 MAG	Members December 31, 1966 AMA Dues Paying Only
Cobb				
J. M. Hodges				
Marietta	125	119	117	115

REFERENCE COMMITTEE RECOMMENDATION—The report of the Cobb County Councilor was accepted with approval and commendation.

HOUSE OF DELEGATES ACTION—Adopted the Reference Committee recommendation as presented.

Woman's Auxiliary Advisory

W. C. Mitchell, M.D., *Chairman*

The committee is happy to report on its activities with, and on behalf of the Woman's Auxiliary.

The Chairman, along with other members of the committee, met with the president and the members of her board at their organizational meeting in the early part of last summer. At this meeting, we were impressed with their interest, enthusiasm, and eagerness to be about their work. There was an air of restlessness permeating the whole affair—a restless desire to be on with and to put behind them their goal of UNLIMITED DIMENSIONS.

With this type of atmosphere, along with an organization so well planned and functioning so smoothly, it is rather hard for an advisor to advise. It appeared to me that we should possibly be asking them for advice in some of our functions.

Our committee has been ready at all times to help in any way it could when called upon to do so. We are pleased to have been consulted on several occasions.

I believe the Medical Association of Georgia, as well as the local county societies, should get to know their auxiliaries better. There are very few of us that know the vast amount of work they do and how little appreciation they receive for their efforts.

RECOMMENDATION

1. That this great potential be used to better advantage. Committees from MAG and Council with similar goals to those of the Auxiliary should work more closely in order to eliminate duplication of effort.

It has been a pleasure and an education to work with this strong and voluntary arm of our Association.

REFERENCE COMMITTEE RECOMMENDATION—The report of the Woman's Auxiliary Advisory Committee was approved with commendation; and the committee recommends approval of the Chairman's recommendation that the corresponding committees of MAG and WMAG seek to further their joint efforts.

HOUSE OF DELEGATES ACTION—Adopted the Reference Committee recommendation as presented.

Annual Session

L. M. Vinton, Jr., M.D., *Chairman*

This committee has followed the regime established so efficiently by the previous chairman, Dr. Thomas Q. Spitzer, and as a result has encountered few difficulties with this session relative to programming and facilities.

We are indebted to the Augusta Town House for its courtesy and assistance in planning and producing this session.

A significant problem has been developing over recent years that has in this session reached a status that cannot be ignored. This is the decreasing number of commercial booth leases augmented by the apparent decreasing interest of the individual physician in commercial exhibits. Continuing surveys by the exhibit chairman following annual session elicits growing dissatisfaction by exhibitors in value received. This is reflected by the lowest number of booths leased for this session in any previous year. Each company failing to lease this year has been written and all cite budgetary limitations. Possible solutions to increase leasing by exhibitors and attendance by physicians have been explored and found meager.

RECOMMENDATION

That the MAG seriously consider abandoning the leasing of space for commercial exhibits and request of pharmaceutical houses donations toward the scientific program instead. That commercial exhibits no longer be sought effective at the end of this session.

Another item which must be noted with possible alarm is the long term planning of conventions by large organizations. This produces competition for suitable convention sites for an organization as large as MAG. This committee would heartily endorse the recommended change in the Constitution and By-laws allowing such forward planning.

REFERENCE COMMITTEE RECOMMENDATION—This committee accepted the report of the Annual Session Committee with commendation, approval and makes the following recommendations: (1) *With regard to the abandoning of leasing of space for commercial exhibits,* it is recommended that commercial exhibits be continued for future Annual Sessions as long as financially and technically feasible; and (2) *Regarding the long term planning of conventions,* the committee endorses the recommended change in the Constitution and By-laws Committee report allowing such forward planning with as much as five years consideration.

HOUSE OF DELEGATES ACTION—Adopted the Reference Committee recommendation as presented.

Supplemental Report of Council No. 2

COMMERCIAL EXHIBITS AT ANNUAL SESSIONS

F. G. Eldridge, M.D., *Chairman*

At the March 1968 meeting of Council a specific recommendation which appears in the Annual Report of the Committee on Annual Session (printed in Delegates Handbook) was discussed at length. Because of the nature of the recommendation Council voted to express its position on this matter for the benefit of the House of Delegates and its Reference Committees which must consider the report of the Committee.

The recommendation in question as stated by the Committee on Annual Session was "That the MAG seriously consider abandoning the leasing of space for commercial exhibits and request of pharmaceutical houses donations toward the scientific program instead. That commercial exhibits no longer be sought effective at the end of this session (1968)."

RECOMMENDATION:

After thorough discussion of this recommendation, the Council voted to express its concurrence with the Annual Session Committee that commercial exhibits at Annual Sessions be terminated. As further developed by Council discussion of this matter, no prohibition is implied against any commercial exhibitor who may wish to exhibit at an MAG Annual Session hotel. However, such exhibits as may be displayed would have to be worked out pursuant to private agreements made with the hotel on such items as space, rental charges, electrical and other necessities as may normally be required by an interested exhibitor. The Annual Session Committee would, of course, reserve the right to veto any inappropriate exhibitor.

Reference Committee Number 5 considering the reports referred to it on Monday afternoon. From left to right are Mrs. Catherine Wooten, MAG Assistant Executive Secretary; Albert A. Rayle, Jr., of Atlanta; Don Schmidt of Cedartown; Cecil White of Augusta; Irving Hellenga of Toccoa; John B. O'Neal of Elberton; and James H. Manning of Marietta.

The Council reached no agreement, however, on that aspect of the recommendation relating to request for donations from pharmaceutical houses and consequently makes no recommendation to the House of Delegates on this point.

REFERENCE COMMITTEE RECOMMENDATION—The committee disapproves the recommendation of Council that commercial exhibits at Annual Sessions be terminated.

HOUSE OF DELEGATES ACTION—Adopted the Reference Committee recommendation as presented.

Maternal and Infant Welfare

EUGENE L. GRIFFIN, M.D., *Chairman*

Under the Chairmanship of Dr. Eugene Griffin, this committee has met four times in regular sessions since the last report. The committee studies every maternal death in some detail, as well as concerning itself with other matters pertaining to the health of mothers and infants over the State. The major areas of activity are listed in brief as follows:

CASE STUDIES

Forty-seven cases were studied, 41 of which were reported as resulting from complications of the prenatal period, obstetrical delivery, and/or the peurperium. There were *89,376* live births in Georgia during 1966; thus, giving a maternal death rate of 4.6 per 10,000 live births. This is the lowest maternal death rate in the history of Georgia. The four leading causes of obstetrical death were pulmonary embolus (7), hemorrhage (6), septicemia (6), toxemia (6). It is also of interest that eight of the deaths were para six or greater.

"GRANNY" MIDWIFE ACTIVITIES

There were 5,735 live births without a medical attendant. This is 951 (14%) less than the previous year. As of the last national report (1965), Georgia ranked 47th of the 50 states with the fewest midwife deliveries. In many areas of Georgia, the communities have developed for the low income high risk obstetrical patients, a plan of obstetrical delivery by a physician, in the hospital. These plans have been accomplished through diligent efforts and close cooperation of the local physicians, hospitals and the health departments of the community. During the past three years no such new community plan was reported where these patients can pay consistent with their means for obstetrical care. Those plans that have been successful are those in which the local physicians have taken the initiative and leadership.

RECOMMENDATION

That MAG urge the district and county medical societies in the State of Georgia to take the leadership in their counties to develop with the hospitals, local health departments and other community resources, a plan whereby all of the medically indigent obstetrical patients may receive hospital and medical care.

PREMATURE BIRTHS

The committee continued to stress the fact that more attention must be given to complications of pregnancy leading to premature labor. For the first time in 20 years, there has been a decrease, even though small, in the rate of premature births. The rate has dropped from 97 per 1,000 live births in 1965 to 94.8 per 1,000 live births in 1966. This problem must be recognized by our association and our endeavors must be directed toward improving this situation.

RECOMMENDATION

That every physician doing obstetrics give particular attention to those complications in past history and the prenatal period known to be associated with premature labor.

BIRTHS TO UNWED MOTHERS

The problem of births to unwed mothers continues to increase consistently every year. In 1966, Georgia had a rate of 113.7 per 1,000 live births. The non-white rate was 266.9 and the rate for white was 30.2 per 1,000 live births. Approximately 12% of all live births in Georgia are to the unwed mother and over 25% of the live births to the non-white are to the unwed mother. Over half of these births are to mothers who are para one or greater prior to the reported pregnancy. The committee has supported and promoted the teaching of education for family living as a part of the curriculum in the school systems. This without doubt, would be of much value in the prevention of unwanted pregnancies in the teenage group.

RECOMMENDATION

That MAG urge the district and county medical societies to encourage and work with their local school systems to include education for family living in their curriculum.

NUTRITION

Iron deficiency anemia continues to be a prenatal problem, especially in the lower socio-economic group of patients. The committee has continued to promote the acceptance of surplus food commodities and food stamp programs offered to every county in the state. During the year, 29 additional counties have initiated one of the programs.

VOLUNTARY STERILIZATION ACT 4584

The administrative mechanism and paper work involved in adhering to the law has been proven cumbersome. The committee has been working with the legal advisor to determine safe ways of simplifying the procedure.

FAMILY PLANNING PROGRAM

The committee has given active support to local and statewide voluntary family planning programs. The intrauterine contraceptive device is being well received by the indigent and medically indigent population with excellent results being indicated to date. During the year, 20,071 indigent and medically indigent new patients were admitted for these services. These programs have been directed primarily to the grand multiparous patient. It is most gratifying to report that since 1964, there has been a very definite drop in the birth rate so that the rate in Georgia is now the lowest recorded in the past 30 years.

CERVICAL CANCER SCREENING PROGRAM

The committee has actively supported the establishment of a statewide cervical cancer screening program sponsored by the Georgia Department of Public Health. With the cooperation of the Georgia Association of

Pathologists and local physicians, this program has been put into effect for the indigent and medically indigent patients in the maternal health clinics of the local health departments. It is an accepted fact that the incidence of cervical carcinoma is much higher in this group of patients. During the first ten months of operation, 10,113 Pap smears were done with 128 being reported as Class III or better. This program is coordinating with the ten local programs to prevent duplication of effort. With this coordinated effort, 133 (84%) of the 159 counties are reached.

LOCAL PHYSICIAN—COMMUNICATION

The committee, on a continuing basis, makes every endeavor to improve liaison and communication with the physicians over the state concerned with maternal and infant care. As a part of this endeavor, the committee met in joint session with the Maternal and Child Health Committee of the Georgia Association of Public Health Physicians. It was jointly agreed that local physicians should be appointed as representatives in obstetrics and pediatrics in order to give statewide liaison coverage. This representation is in the process of being established in cooperation with local medical societies. Both committees felt that this was a positive step in improving maternal and infant health.

LEGISLATION

During the year, the committee actively participated in writing up proposed legislation concerning therapeutic abortions.

The committee also supported the Amendment to Act 427, Georgia Laws 1966, entitled Family Planning Services Act. This Amendment would broaden the eligibility of patients for family planning programs to include the mentally retarded and should have some impact on the problem of unwed mothers.

PERINATAL MORBIDITY AND MORTALITY

The committee shares the concern of the American Medical Association for the need for more studies in the field of perinatal mortality. The perinatal morbidity and mortality subcommittee was reactivated and is in the process of analyzing the problem. Questionnaires have been sent to all pertinent hospitals to help in locating the local hospital committees already established. It is planned a representative of this committee will meet with the local committees to get suggestions and work with them in developing a statewide standard cause of death classification and statistical analysis.

REFERENCE COMMITTEE RECOMMENDATION—The committee endorses this report with commendation and recommends approval of the recommendations.

HOUSE OF DELEGATES ACTION—Adopted the Reference Committee recommendations as presented.

Nursing Liaison

CHARLES EBERHART, M.D., *Chairman*

During 1967-68, there has been increasing comment in the press relative to the nationwide nurse shortage and expressions or opinion about nursing educational philosophies. At its July 1967 meeting, the AMA House of Delegates re-affirmed its support of all forms of nursing educational programs. Because of the shortage of nurses, the AMA emphasized the necessity of continuing operation of the Diploma (Hospital) Schools of Nursing.

Five Diploma schools are scheduled for closure in Georgia during 1968. These probably will never reopen. The National League of Nursing and the American Nurses Association position papers call for this. The former is the accrediting agency for schools of nursing. Although the National League of Nursing professes fear of the accelerated closure of Diploma schools, they apply unrelenting pressure upon them in many ways.

The Nurse shortage has been growing over the past 20 years. While it is readily admitted that there is a growing man-power shortage and an ever expanding frontier for nurses, it is felt that the nurse shortage has been made artificially more severe because of the National League of Nursing. This is a policy of forcing closure of Diploma schools which are still producing an estimated 70 percent of nurses.

The MAG membership should be appraised of the following facts. In 1966, of 885 graduates of Georgia schools of nursing who took the State Board Test Pool Examination, 557 passed and 328 (37.67%) failed. In 1967, a lesser number, 647 took the examination. Only 486 passed while 161 failed. Re-examinations were given to 475 with 177 passing and 302 failing. This made a total of 663 Georgia graduates for 1967. The explanation for the staggering failure rate is unknown. It seems that a person who has withstood the rigors of three years of academic education should be qualified to become a licensed nurse. This is particularly true in view of the fact that applicants for Diploma Schools are selected from the upper half of their high school classes.

There is one encouraging development. The State Legislature appointed a group known as the Georgia Education Improvement Council. It was activated this year. An advisory committee concerned with nursing education has been formed and MAG is represented. It is hoped that this committee will cast light on the possibility of increasing the number of nurses.

On October 6, 1967 representatives of 46 of the State Medical Society's Liaison Committees of Nursing met with the AMA Committee on Nursing at AMA Headquarters.

Our Committee offers the following resolution for passage by MAG House of Delegates.

Nursing Liaison

Diploma Schools of Nursing

CHARLES EBERHART, M.D., *Chairman*

WHEREAS, the American Medical Association House of Delegates has re-affirmed its support of all forms of Nursing educational programs and particularly called for continuation of the Diploma (Hospital) Schools of Nursing, and

WHEREAS the nation-wide shortage of nurses is becoming more acute and,

WHEREAS, five Diploma Schools of Nursing are scheduled for closure in 1968 in Georgia, and

WHEREAS, little will be accomplished by allowing an established Diploma Program to fall into disuse with a shift of students to a program with an uncertain future,

THEREFORE BE IT RESOLVED, that the MAG House of Delegates recommend:

(1) That MAG go on record as strongly supporting the continuation of the Diploma Schools of Nursing, and

(2) That the authorities responsible for the operation of these schools make known to MAG the manner of relief needed for them to continue in operation, and

(3) That a copy of this resolution be sent to the authorities of all Diploma Schools of Nursing in Georgia, The Georgia State Nurses Association and The National League of Nursing.

REFERENCE COMMITTEE RECOMMENDATION—The committee endorses the report with commendation and recommends that the Resolution in the report be adopted by the House of Delegates.

HOUSE OF DELEGATES ACTION—Adopted the Reference Committee recommendation as presented.

Ad Hoc Committee on Charting

CHARLES T. COWART, M.D., *Chairman*

The Ad Hoc Committee on Hospital Charting had its first and only meeting on August 2, 1967. It was agreed that the chairman should write the Joint Commission on Accreditation of Hospitals for data relative to what would be acceptable. Also, Dr. Asa Yancey was to contact IBM regarding the possible use of data processing in charting.

The chairman received a letter full of interest and good wishes, but nothing specific from the Joint Commission. Dr. John D. Porterfield did state that various studies are presently underway. He referred to the large study at Massachusetts General Hospital supported by the American Hospital Association. He also referred to The Medi-Data Corporation serving hospitals in the Carolinas which is attempting to harness a regional computer mechanism. The committee will attempt to follow these studies while it is still trying to work out a system of its own.

We have had no response from IBM.

RECOMMENDATION

1. That an Ad Hoc Committee on Charting be appointed for the next year to continue this work.

REFERENCE COMMITTEE RECOMMENDATION—The committee recommends approval of this report with commendation.

HOUSE OF DELEGATES ACTION—Adopted the Reference Committee recommendation as presented.

Resolution No. 5

ANNUAL MEETING HOUSE OF DELEGATES —MEDICAL ASSOCIATION OF GEORGIA

JACK A. RAINES, M.D.
SIMONE BROCATO, M.D.

For Muscogee County Medical Society

WHEREAS, The Atlanta Graduate Medical Assembly held each year in Atlanta, Georgia, brings to this state an outstanding array of Scientific Programs, and

WHEREAS, the Annual Session of the Medical Association of Georgia is held shortly after the Atlanta Graduate Medical Assembly and is in many instances a duplication of scientific programs.

NOW THEREFORE BE IT RESOLVED, That the Muscogee County Medical Society asks that the Business Sessions of the House of Delegates of the Medical Association of Georgia be held at the same time as the Atlanta Graduate Medical Assembly.

REFERENCE COMMITTEE RECOMMENDATION—The committee recommends disapproval of this Resolution with the feeling that the MAG Annual Session should retain its own identity and not be absorbed in another organization's meeting.

HOUSE OF DELEGATES ACTION—Adopted the Reference Committee recommendation as presented.

Late Report No. 3

REPORT OF VOLUNTARY HEALTH AGENCIES COMMITTEE

P. T. SCOGGINS, *Commerce*

We have not met this year due to the fact that the AMA Board had nothing new to submit.

I think this Board should still be available and each member in his district should insist that a member of Medical Association of Georgia be a member of any voluntary health agency. We should also encourage the doctor to serve on these agencies.

REFERENCE COMMITTEE RECOMMENDATION—The committee recommends approval of this report.

HOUSE OF DELEGATES ACTION—Adopted the Reference Committee recommendation as presented.

Ninth District Councilor

P. T. SCOGGINS, M.D., *Commerce*

Counties and Secretaries	Members December 31, 1967 MAG	Members December 31, 1967 AMA Dues Paying Only	Members December 31, 1966 MAG	Members December 31, 1966 AMA Dues Paying Only
Barrow				
E. H. Etheridge				
Winder	7	6	7	6
Blue Ridge				
C. M. Berry				
Ellijay	7	5	8	5
Chattahoochee				
C. B. Teal, Jr.				
Lawrenceville	20	14	20	16
Cherokee-Pickens				
A. M. Hendrix				
Canton	15	15	14	13
Elbert-Franklin-Hart				
T. B. Tanner				
Hartwell	24	9	23	13
Habersham				
T. L. Hodges				
Clarkesville	14	11	14	11
Hall				
A. D. Wright, Jr.				
Gainesville	60	57	57	52
Jackson-Banks				
A. A. Rogers, Jr.				
Commerce	9	6	9	7

Rabun				
Richard J. Turner				
Clayton	2	2	3	3
Stephens				
C. M. Henry				
Toccoa	16	15	19	18
	174	130	174	144

Late Report No. 4

REPORT OF NINTH DISTRICT COUNCILOR

P. T. Scoggins, *Commerce*

Ninth District has been represented at all Council meetings this past year. Our report has been made to Ninth District Medical Society at both meetings.

We have 153 Medical Association of Georgia members and 130 American Medical Association members. An effort will be made this year to increase the membership. It should be noted that Hall County Medical Society was 100 per cent in dues to MAG and AMA.

I appreciate the active support given me by our Vice Councilor.

REFERENCE COMMITTEE RECOMMENDATION—The committee recommends approval of this Councilor's report.

HOUSE OF DELEGATES ACTION—Adopted the Reference Committee recommendation as presented.

Resolution No. 12

ABBREVIATED PROGRAMS OF TRAINING IN RADIOLOGIC TECHNOLOGY

Charles M. Silverstein, M.D.
For Georgia Radiological Society

WHEREAS, there is a shortage of qualified radiologic technologists in Georgia although there are now 21 approved schools of radiologic technology associated with licensed hospitals in Georgia. Most of these schools have places open and can accommodate more students. Scholarships are available for this program, which requires at least two years for adequate training.

WHEREAS, private enterprise training programs which are not connected with licensed hospitals and which purport to qualify trainees, in abbreviated training periods, as x-ray (radiologic) technologists do not really qualify trainees and do not provide a satisfactory answer to the problem of technologist shortages.

THEREFORE BE IT RESOLVED, that physicians should encourage those interested to enter recognized hospital-connected schools of radiologic technology and should discourage aspiring technologists from enrolling in programs which are substandard.

REFERENCE COMMITTEE RECOMMENDATION—The committee recommends acceptance of Resolution No. 12 with approval, and also recommends that a copy of this Resolution be sent to all hospitals and medical societies in Georgia.

HOUSE OF DELEGATES ACTION—Adopted the Reference Committee recommendation as presented.

Chairman White then reported that this concluded the report of the Reference Committee No. 5, and moved for the adoption of his report as a whole by the House of Delegates with appreciation to the members of his Committee. This motion was duly seconded and approved.

Speaker Rogers then called for Unfinished Business, and there being none, Dr. Rogers opened the floor for New Business. There being no New Business, Speaker Rogers thanked each and every member of the Reference Committees for their diligent work and the entire MAG Office Staff for their assistance, and entertained a motion for the adjournment of the Second Session of the MAG House of Delegates meeting in conjunction with the 114th Annual Session of the Association. On motion duly made and seconded, the House was adjourned at 12:15 p.m.

AAGP ANNOUNCES NEW PRACTICE MANAGEMENT GUIDE

A 105-page manual designed to provide the general or family physician with professional help in handling the complicated business aspects of medical practice and the important community and professional relationships involved has been developed by the American Academy of General Practice.

The manual, "Organization and Management of Family Practice," attempts to fill an urgent need for expert advice in an area largely neglected by medical schools and professional organizations. It is aimed at the graduate who wishes to avoid costly errors in establishing his first practice, and the practicing physician who wants to evaluate the efficiency of his present office procedures.

The illustrated handbook contains three major sections, including an introductory description of the content of family practice and the functions of the family doctor; a major middle section dealing with the business of running an office practice, and a third part describing the community resources and professional associations available to the practicing physician.

Members of the Society of Professional Business Consultants, a national association of business management consultants, were retained to study the unique problems of running a medical practice and to develop the 50-page middle section on Practice Organization and Management.

The manual is being made available to all Academy members. It also will be made available free of charge on request to medical students, interns, residents and medical school and hospital libraries. Others interested in obtaining a copy may do so at $1 per copy from the American Academy of General Practice, Volker Blvd. at Brookside, Kansas City, Mo. 64112.

MAG General Business Session (First Session)

114th Annual Session of the Medical Association of Georgia

Sunday, May 5, 1968

THE FIRST GENERAL BUSINESS SESSION of the 114th Annual Session of the Medical Association of Georgia was called to order by President John Mauldin, Atlanta, at 5:05 p.m., in the Embassy Room, Augusta Town House Motor Inn, Augusta, Georgia, on May 5, 1968.

Dr. Mauldin welcomed those members present, and stated that the purpose of the meeting this afternoon concerned the nominations of MAG Officers, Councilors and Vice Councilors, MAG Delegates and Alternate Delegates to the American Medical Association, and finally, to receive nominations for the MAG General Practitioner of the Year Award.

The new MAG President-Elect John Kirk Train of Savannah.

Tellers Committee

Before proceeding with the business, President Mauldin announced the appointment of the Tellers Committee to take charge of the official MAG Ballot Box as follows: Walter Brown, Savannah, Chairman; George Alexander, Forsyth; and J. G. McDaniel, Atlanta.

President Mauldin then read from the Bylaws the eligibility requirements for voting, announced the location of the Ballot Box, and stated that the hours for voting as set by the MAG Council were to be at the close of that Session, May 5, 5:30 p.m. to 6:30 p.m.; May 6, 9:00 a.m. to 6:00 p.m. at which time the Ballot Box is closed so that election results may be tabulated and announced at the Tuesday morning May 7 Business Session.

Nominations

President Mauldin called for nominations from the floor for the Association's Officers and the following nominations were made:

President-Elect—John Kirk Train, Savannah, nominated by Walter Brown; seconded by Preston Ellington, J. Frank Walker, Roy Gibson, and Charles R. Andrews, Jr.

There being no other nominations for the office of President-Elect, on motion duly made and seconded, the nominations were closed and President Mauldin instructed the Secretary to cast a unanimous ballot for John Kirk Train as President-Elect of the Medical Association of Georgia.

Second Vice President—Ronald Galloway, Augusta, nominated by M. C. Adair; seconded by Thomas Goodwin, Luther Vinton, B. L. Shepard, and Henry Scoggins.

There being no other nominations for the office of Second Vice President, on motion duly made and seconded, the nominations were closed and President Mauldin instructed the Secretary to cast a unanimous ballot for Ronald Galloway as Second Vice President of the Medical Association of Georgia.

President Mauldin noted that according to MAG Bylaws as revised in 1966, under Chapter V, Section 2, Nominations, it stated that if a District Society or a Component County Medical Society is entitled to direct representation by one or more Councilors and Vice Councilors, the Secretary of the MAG must receive, no later than 15 days before the Annual Session, written notice of the election of Councilors and Vice Councilors, that these Councilors and Vice Councilors may be considered by the Association as duly elected, and nominations from the floor are only to be accepted in the absence of such notification of election to the Secretary of MAG 15 days in advance of an Annual Session. President Mauldin stated that he was happy to report that the District and County Medical Societies, whose Councilors' and Vice Councilors' terms of office had expired, had duly notified MAG of their election and that no nominations from the floor were then in order. Dr. Mauldin then read the notification of these elections as received by MAG from the Secretary of the respective District and County Medical Societies as follows:

Due to the resignation of Dr. Homer L. Lassiter, Arlington, President Mauldin announced that an election was held by the Second District to fill the unexpired term until 1970. The result of that election was that the Second District Vice Councilor would be Randolph A. Malone, Thomasville—1968-70.

Sixth District Councilor—Ernest Proctor, Newnan —1968-71

Sixth District Vice Councilor—Norman Gardner, Thomaston—1968-71

Seventh District Councilor—David A. Wells, Dalton —1968-71

Seventh District Vice Councilor—Don Schmidt, Cedartown—1968-71

Eighth District Councilor—Franklin G. Eldridge, Valdosta—1968-71

Eighth District Vice Councilor—Robert E. Perry, Jr., Brunswick—1968-71

Tenth District Councilor—(To fill the unexpired term of Addison W. Simpson) William Rawlings, Sandersville—1968-69

Tenth District Vice Councilor—(To fill the unexpired term of William Rawlings)—Marion Hubert, Athens—1968-69

Fulton County Medical Society Councilor—John T. Godwin, Atlanta—1968-71

Fulton County Medical Society Vice Councilor—J. Norman Berry, Atlanta—1968-71

Fulton County Medical Society Vice Councilor—(To fill the unexpired term of Frank L. Wilson) William W. Moore, Jr., Atlanta—1968-70

Muscogee County Medical Society Councilor—Roy L. Gibson, Columbus—1968-71

Muscogee County Medical Society Vice Councilor—Louis A. Hazouri, Columbus—1968-71

AMA Delegates and Alternate Delegates

President Mauldin called for nominations for MAG Delegates to the American Medical Association and stated that he would identify the elective posts by announcing the name of the incumbent in office and also by giving the term of office.

AMA Delegate (for the office held by J. Frank Walker, Atlanta; the term beginning January 1, 1969, and expiring December 31, 1970)—J. Frank Walker, Atlanta, nominated by J. Rhodes Haverty; seconded by Don Cathcart and Walter Brown.

There being no further nominations, on motion duly made and seconded, it was voted to close the nominations and President Mauldin instructed the Secretary to cast a unanimous ballot for the election of J. Frank Walker.

AMA Alternate Delegate (for the office held by John Kirk Train, Savannah; the term beginning January 1, 1969, and expiring December 31, 1970)—John T. Mauldin, Atlanta, nominated by Harry Pinson; seconded by Luther Wolff, L. W. Griffin, and J. W. Chambers.

J. D. Bateman, Albany, nominated by Robert Waller; seconded by J. T. Christmas, Henry Scoggins, Joseph Mulherin, Allen Turner, Neal Yeomans, and W. P. Smith.

There being no further nominations, on motion duly made and seconded it was voted to close the nominations.

AMA Delegate (for the office held by Preston D. Ellington, Augusta; term beginning January 1, 1969, and expiring December 31, 1970)—Preston D. Ellington, Augusta, nominated by Stuart D. Prather; seconded by J. W. Chambers.

There being no further nominations, on motion duly made and seconded, it was voted to close the nominations, and President Mauldin instructed the Secretary to cast a unanimous ballot for the election of Preston D. Ellington.

AMA Alternate Delegate (for the office held by F. W. Dowda, Atlanta; the term beginning January 1, 1969, and expiring December 31, 1970)—F. W. Dowda, Atlanta, nominated by Preston D. Ellington; seconded by Henry Jennings, John Kirk Train and Linton Bishop.

There being no further nominations, on motion duly made and seconded, it was voted to close the nominations, and President Mauldin instructed the Secretary to cast a unanimous ballot for the election of F. W. Dowda.

GP of the Year Award

President Mauldin announced that no nominations for General Practitioner of the Year Award were received in advance by the MAG Headquarters Office. Nominations for this year's recipient were deferred until the Second Session of the MAG General Business Session on Monday morning, May 6.

There being no further business, the First General Business Session of the 114th Annual Session of the Medical Association of Georgia was recessed at 5:55 p.m.

MAG General Business Session (Second Session)

114th Annual Session of the Medical Association of Georgia

Monday, May 6, 1968

THE SECOND GENERAL BUSINESS SESSION of the 114th Annual Session of the Medical Association of Georgia was called to order by President John T. Mauldin, Atlanta, at 9:05 a.m., in the Embassy Room, Augusta Town House Motor Inn, Augusta, Georgia, on May 6, 1968.

President Mauldin called on Dr. Tom Goodwin to escort the Rev. John G. Parks, Jr., Pastor of the First Presbyterian Church of Augusta, to the stand to give the invocation.

The official welcome to the Association's membership was delivered by Stuart H. Prather, Jr., Augusta, President of the Richmond County Medical Society, in behalf of the membership of that county society hosting the 114th Annual Session.

President Mauldin then called on Bill Fuller to escort the Honorable George Sancken, Jr., Mayor of Augusta, to the stand, who welcomed the MAG members to the City of Augusta.

President Mauldin then called on President-Elect Charles R. Andrews, Jr., Canton, who presented his Incoming President's Address to the Association's membership on "Our Association's Future for 1968-69" (This President-Elect's speech and the action pursuant to it, will be found in the proceedings of the House of Delegates to which it was assigned.)

President Mauldin then called on Franklin Eldridge, Valdosta, to escort Mrs. Haywood Phillips, Augusta, President-Elect of the Woman's Auxiliary to the Medical Association of Georgia, to the stand where she delivered the report of the MAG Auxiliary in behalf of Mrs. James H. Manning, Marietta, President of the MAG Auxiliary.

GP of the Year Award

President Mauldin then recognized Robert E. Huie, Decatur, who placed in nomination George Alexander of Forsyth for General Practitioner of the Year Award. Dr. Alexander's nomination was seconded by Fred Simonton and Irving D. Hellenga. President Mauldin announced that George Alexander was elected by acclamation and this was symbolized by a rising vote of the House.

MAG Memorial Service

President Mauldin then closed the Second MAG General Business Session on a solemn note with the convening of the annual MAG Memorial Service. President Mauldin read the names of these departed colleagues as follows:

Clara B. Barrett, Atlanta, February 1, 1968
Gregory Bateman, Atlanta, February 28, 1968
W. W. Battey, Augusta, January 12, 1968
Richard A. Billings, Atlanta, February 6, 1968
Robert T. Carney, East Point, July 17, 1967
F. E. Christopher, Atlanta, December 7, 1967
T. H. Clark, Douglas, October 18, 1967
C. A. Clements, Trion, July 31, 1967
Melvis O. Corbitt, Augusta, December 29, 1967
Frank M. Cronic, Macon, January 19, 1968
John W. Daniel, Jr., Savannah, December 20, 1967
J. E. Davis, Atlanta, December 19, 1967
Tudor C. Davis, Atlanta, July 28, 1967
W. B. Duvall, Atlanta, July 27, 1967
C. W. Dyer, Macon, February 15, 1968
G. H. Faggart, Savannah, August 18, 1967
R. W. Fowler, Sr., Marietta, October 28, 1967
Odis G. Glover, East Point, August 9, 1967
E. N. Gleaton, Savannah, January 17, 1968
Richard C. Hackney, Atlanta, February 7, 1968
E. C. Herman, LaGrange, September 16, 1967
W. G. Hicks, Jackson, November 12, 1967
W. Lynn Hicks, McCaysville, May 18, 1967
J. T. Holt, Baxley, April 28, 1967
H. P. Hyde, Copperhill, Tennessee, October 6, 1967
Victoria I. Johnston, Brunswick, November 12, 1967
H. T. Jones, West Point, September 18, 1967
Claude T. Key, Atlanta, October 4, 1967
Frank R. Mann, McRae, February 23, 1968
F. T. McElreath, Tennille, April 4, 1968
O. D. Middleton, Hinesville, June 16, 1967
W. E. Mobley, Macon, August 25, 1967
M. Fernan Nunez, Savannah, June 18, 1967
F. B. Pickett, Tifton, March 1, 1968
A. G. Pinkston, Jr., Glennville, August 24, 1967
David Henry Poer, Atlanta, June 14, 1967
Albert A. Rayle, Sr., Atlanta, May 12, 1967
D. S. Reese, Carrollton, August 9, 1967
Ivan B. Ross, Atlanta, January 11, 1968
Jose A. Samra, Hapeville, June 15, 1967
C. C. Shipp, Thomasville, July 13, 1967

Addison W. Simpson, Jr., Washington, May 11, 1967
Randolph Smith, Decatur, June 1, 1967
Phillip R. Stewart, Monroe, April 23, 1967
C. Griggs Thomason, East Point, November 17, 1967
O. R. Thompson, Macon, October 15, 1967
Charles B. Upshaw, Sr., Atlanta, May 10, 1967
E. Y. Walker, Milledgeville, August 3, 1967
William H. Wall, Blakely, July 19, 1967
John J. Westermann, Jr., Sea Island, February 7, 1968
M. W. Williams, Camilla, December 29, 1967
Otis C. Woods, Milledgeville, March 2, 1968

President Mauldin called on the House to stand for a moment of silent prayer in recognition of these departed colleagues.

There being no further business, President Mauldin adjourned the Second MAG General Business Session at 9:40 a.m.

Earl T. McGhee of Dalton (left) and James A. Kaufman of Atlanta (second from right) are shown with Lt. Governor George T. Smith and Comptroller-General James Bentley who were presented Certificates of Appreciation for Distinguished Service by MAG.

GEORGIA HIGHWAY SLAUGHTER

Yearly Totals

1968 to date	511 Killed
1967	1,617 Killed
1966	1,605 Killed
1965	1,354 Killed
1964	1,314 Killed
1963	1,278 Killed
1962	1,106 Killed
1961	1,017 Killed

Through April 1968
511 KILLED

Same Period 1967
501 KILLED

April 1968
112 KILLED

Economic Loss

1968 to date	$ 97,090,000
1967	307,230,000
1966	288,900,000
1965	243,720,000
1964	236,520,000
1963	230,040,000
1962	199,080,000
1961	162,720,000

MAG General Business Session (Third Session)

114th Annual Session of the Medical Association of Georgia

Tuesday, May 7, 1968

THE THIRD GENERAL BUSINESS SESSION of the 114th Annual Session of the Medical Association of Georgia was called to order by President John T. Mauldin, Atlanta, at 9:05 a.m., in the Embassy Room, Augusta Town House Motor Inn, Augusta, Georgia, on May 7, 1968.

Fifty-Year Certificates

Immediate Past President Walter E. Brown, Savannah, presented MAG Fifty-Year Certificates and Pins to physician members who have practiced medicine for 50 years or more. These presentations were made to the following physicians:

Mercer Blanchard, Columbus; Walter C. Goodpasture (Deceased), Atlanta; Robert B. Goldin, Rockmart; John Erwin Penland, Waycross; Wyman Platt Sloan, Sr., Atlanta; Joseph Yampolsky, Atlanta.

Scientific Exhibits Awards

John N. McClure, Atlanta, Chairman of the Association's Scientific Exhibit Awards Committee, made the following presentations:

First Place Award—"The Spectrum of Gonadal Dysgenesis"

Robert B. Greenblatt, M.D.; J. R. Byrd, Ph.D.; V. B. Mahesh, Ph.D.; and P. G. McDonough, M.D., Augusta, Georgia

Second Place Award—"Intravenous Regional Anesthesia"

Carl A. Smith, M.D.; C. Doyle Haynes, M.D.; and John E. Steinhaus, M.D., Atlanta, Georgia

Third Place Award—"Experimental Decompression of the Duodenal Stump"

C. Martin Rhode, M.D.; Von B. Pittman, M.D.; and W. D. Jennings, Jr., M.D., Augusta, Georgia

Scientific Exhibits Chairman John McClure also presented the "Aesculapius Award" sponsored by Mead Johnson Company for excellence in scientific exhibits. This award was presented in addition to the First Place Award to Dr. Robert B. Greenblatt, Augusta, for his exhibit entitled, "The Spectrum of Gonadal Dysgenesis."

GP of the Year Award

Robert E. Huie, Decatur, President of the Georgia Academy of General Practice, presented the Medical Association of Georgia "GP of the Year Award" to George H. Alexander of Forsyth.

George H. Alexander of Forsyth is shown with his award as General Practitioner of the Year. Robert E. Huie of Decatur, President of the Georgia Academy of General Practice, presented the award to Dr. Alexander.

Certificates of Appreciation

MAG Secretary John Rhodes Haverty, Atlanta, presented Medical Association of Georgia Certificates of Appreciation to persons recognized by the Association for their activities in behalf of the Medical Association of Georgia. Dr. Haverty presented these certificates as follows:

John T. Mauldin, M.D., as MAG President, 1967-68; M. C. Adair, M.D. as MAG First Vice President, 1967-68; J. Frank Walker, M.D. as Speaker, MAG House of Delegates, 1961-68; Homer L. Lassiter, M.D. as Second District Vice Councilor, 1966-68; Charles T.

Cowart, M.D. as Sixth District Councilor, 1966-68; Ralph N. Johnson, M.D. as Seventh District Councilor, 1962-68; Linton H. Bishop, M.D. as Fulton County Medical Society Councilor, 1965-68; Frank L. Wilson, Jr., M.D. as Fulton County Medical Society Vice Councilor, 1963-68; Mrs. James H. Manning as President, Woman's Auxiliary to MAG, 1967-68; Albert M. Deal, M.D. as Chairman, Board of Medical Examiners; C. C. Moreland, M.D. for Distinguished Service to Medicine in the General Assembly, 1967-68; Honorable James L. Bentley, Jr., Comptroller General, for Devoted Service to the People of Georgia; Honorable George T. Smith, Lt. Governor, for Outstanding Service to Georgia in the Field of Medical Legislation; and J. W. Yeomans, M.D. for Eighth District Vice Councilor, 1963-68.

GaMPAC Awards

President Mauldin then recognized Earnest C. Atkins, Decatur, Chairman of the Georgia Medical Political Action Committee, for the purpose of presenting GaMPAC Awards this year for the first time. Dr. Atkins presented to Tom Sappington, representing Upson County Medical Society, the award for the highest percentage of GaMPAC membership in the State during the year 1967.

Dr. Atkins presented to Luther Vinton, representing the Fourth Congressional District, a plaque recognizing them for having the highest percentage of GaMPAC membership for 1967. Dr. Atkins then presented to Ralph Newton, representing the Bibb County Medical Society, the plaque for obtaining the largest dollar contribution to the Georgia Medical Political Action Committee for 1967.

Hardman Award

President Mauldin then called on Incoming President, Charles R. Andrews, Jr., who reported that the 1968 recipient for the Medical Association of Georgia Hardman Award and Certificate was John Willis Hurst, Atlanta.

AMA Certificates of Humanitarian Service

President Mauldin then called on MAG Secretary, John Rhodes Haverty, to present the AMA Certificates of Humanitarian Service to those members who voluntarily gave their time and talents to the treatment of the sick in Viet Nam. Dr. Haverty presented certificates to the following: Edwin L. Brackney, M.D., Augusta; Bruce F. Caldwell, M.D., Augusta; Charles C. Wike, M.D., Augusta; and Charles H. Wray, M.D., Augusta.

Site of Future Annual Sessions

President Mauldin then announced that the 1969 Annual Session will be held on May 4-6, 1969, in Savannah. He then explained that due to the competition of meeting space and desirable dates, it was the Association's wish that Annual Session invitations be tended for 1970 and 1971, which would enable the staff to secure the best possible accommodations and begin to make plans now. Dr. Mauldin then read a letter from Councilor Braswell Collins, in the name of the Bibb County Medical Society, inviting MAG to meet in Macon in 1970.

Dr. Mauldin then recognized Jesse L. Hunt, Brunswick, who presented an invitation from the Glynn County Medical Society to hold the 1970 Annual Session at Jekyll Island.

President Mauldin then recognized Linton Bishop, Atlanta, who invited the MAG to holds its 1971 Annual Session in Atlanta.

President Mauldin stated that he would refer these invitations to the Council, which would decide on the future meeting sites based on the availability of desirable dates and space.

Official Attendance Record

President Mauldin announced the official attendance at the 114th Annual Session of the Medical Association of Georgia held in Augusta, Georgia, May 5-7, 1968 was as follows:

MAG Members—536, Guests—82, Exhibitors—101; and Auxiliary—238; thereby making a grand total of 957 registered.

Election Results

President Mauldin announced the MAG Election returns as reported by the Chairman of the Tellers Committee, Walter E. Brown, as follows:

President-Elect: John Kirk Train, Savannah
Second Vice President: Ronald F. Galloway, Augusta
AMA Delegate: J. Frank Walker, Atlanta
AMA Alternate Delegate: J. Daniel Bateman, Albany
AMA Delegate: Preston D. Ellington, Augusta
AMA Alternate Delegate: F. W. Dowda, Atlanta

Installation of Officers

The final order of business was the installation of 1968-69 Officers and Councilors and Delegates as follows:

President—Charles R. Andrews, Jr., Canton (1969)
President-Elect—John Kirk Train, Savannah (1969)
Immediate Past President—John T. Mauldin, Atlanta (1971)
First Vice President—Fleming L. Jolley, Atlanta (1969)
Second Vice President—Ronald F. Galloway, Augusta (1969)
Second District Vice Councilor—Ronald A. Malone, Thomasville (1970)
Sixth District Councilor—Ernest Proctor, Newnan (1971)
Sixth District Vice Councilor—Norman Gardner, Thomaston (1971)
Seventh District Councilor—David A. Wells, Dalton (1971)

Seventh District Vice Councilor—Don Schmidt, Cedartown (1971)

Eighth District Councilor—Franklin G. Eldridge, Valdosta (1971)

Eighth District Vice Councilor—Robert E. Perry, Jr., Brunswick (1971)

Tenth District Councilor—William Rawlings, Sandersville (1969)

Tenth District Vice Councilor—Marion Hubert, Athens (1969)

Fulton County Medical Society Councilor—John T. Godwin, Atlanta (1971)

Fulton County Medical Society Vice Councilor—J. Norman Berry, Atlanta (1971)

Fulton County Medical Society Vice Councilor—William W. Moore, Jr., Atlanta (1970)

Muscogee County Medical Society Councilor—Roy L. Gibson, Columbus (1971)

Muscogee County Medical Society Vice Councilor—Louis A. Hazouri, Columbus (1971)

AMA Delegate—J. Frank Walker, Atlanta (January 1, 1969-December 31, 1970)

AMA Alternate Delegate—J. Daniel Bateman, Albany (January 1, 1969-December 31, 1970)

AMA Delegate—Preston D. Ellington, Augusta (January 1, 1969-December 31, 1970)

AMA Alternate Delegate—F. W. Dowda, Atlanta (January 1, 1969-December 31, 1970)

Outgoing President John T. Mauldin has presented the gavel to the new President, Charles R. Andrews, and the 114th Annual Session is about to adjourn.

Outgoing President Mauldin then turned over the gavel of leadership to incoming President Charles R. Andrews, who expressed his appreciation to the membership for their cooperation and interest, and there being no further business, President Andrews adjourned the 114th Annual Session of the Medical Association of Georgia at 12:10 p.m.

Vacation trip....

Motion sickness?

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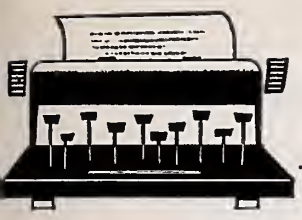


EDITORIALS

John Kirk Train of Savannah Is New MAG President-Elect

JOHN KIRK TRAIN, JR., OF SAVANNAH, a specialist in otology, laryngology and rhinology, became the new President-Elect of the Medical Association of Georgia at the 114th Annual Meeting of the Association in Augusta. He was unopposed for the post.

Dr. Train, the son of a physician, is a Savannah native who received his B.A. from Yale University in 1934 and his medical degree from the University of Virginia in 1938. He interned at the Bellevue Hospital in New York City until 1940 and returned to the University of Virginia for his residency in otolaryngology and ophthalmology. From 1943 to 1946 he was on active duty in the Medical Corps of the United States Naval Reserve and since that time has been in private practice in Savannah.

Active in the Georgia Medical Society as well as the Medical Association of Georgia, Dr. Train served as President of the Georgia Medical Society in 1961 and as a member of that group's Board of Trustees from 1962 to 1967. He was the Georgia Medical Society's Vice Councilor to the MAG from 1963 to 1967. Dr. Train was Second Vice President of the Medical Association of Georgia in 1964, First Vice President in 1965 and Alternate Delegate to the American Medical Association from 1964 to 1968.

Among Dr. Train's community activities are membership on the Health and Hospital Planning Commission of Chatham County, representative from the Georgia Medical Society to the Savannah Foundation, and vestryman of St. John's Church in Savannah. He is a Past President of the Medical and Dental Staff of St. Joseph's Hospital and of the Candler General Hospital, both in Savannah, as well as former senior warden of St. John's Church.

Dr. Train is married to the former Ann Bradford of Staunton, Virginia. His son, John Kirk, III, is a member of the law firm Alston, Miller and Gaines in Atlanta; daughter Sally teaches at Georgia State College in Atlanta and his younger daughter, Susan, is a student at Mary Baldwin College in Virginia.

Highlights of the 1968 MAG Annual Session

THE 114TH ANNUAL SESSION of the Medical Association of Georgia was convened in Augusta, Georgia, on May 5-7, 1968. The two and a half day meeting was well attended by physicians, their wives and guests from across the State. In addition to a full scientific program which included eighteen out-of-state physician guest speakers, there were also meetings of the MAG House of Del-

egates, general business sessions, election of officers, presentation of awards and numerous related events.

The MAG General Assembly drew enthusiastic response with the presentation of a top flight panel on "Efficiency in Medical Practice" and the address of United States Senator Paul J. Fannin of Arizona.

Among the many subjects contained in reports and resolutions presented to the House of Delegates for consideration were: permanent hospital appointments; physician representation on hospital governing boards; central billing of dues by the Headquarters Office; hospital insurance; hospital privileges for qualified medical practitioners; Headquarters Building expansion; method of electing MAG officers; MAG Foundation; drug abuse; and Annual Session commercial exhibits. A detailed report of each proposal, the subsequent recommendation of the Reference Committee and the final action of the House of Delegates appear elsewhere in this issue of the *Journal.*

Permanent Hospital Assignments

The report of the Ninth District Vice Councilor recommended that the House go on record in support of permanent hospital staff assignments rather than continuation of annual appointments. This was approved by the House of Delegates.

Physician Representation on Hospital Governing Boards

One report and two resolutions on variations of the theme that hospital governing boards should contain physician representation were introduced. After lengthy discussion it was recommended and approved by the House that MAG seek the passage of legislation to require ". . . at least one full voting member of the governing board of every hospital approved by the Georgia State Department of Health to be an active staff member of that hospital engaged in the private practice of medicine and that his appointment be made for a specified period of time and not on a permanent basis."

Central Billing

The House approved the central billing of MAG dues on a County Medical Society option basis. The effect of the House action will be: those County Medical Societies who wish to have MAG bill their members direct for county, MAG, AMA and other dues will furnish MAG the names and amounts to bill for and MAG will in turn rebate to local societies their prorata share of the dues collected; those county societies who wish to continue to bill for local, state, AMA and other dues will do so. In a separate action, also on the matter of billing for dues, the House approved the recommendation that district society dues be included on the county society dues statement.

In still a third action relating to dues, the House approved a report "that Council strongly consider recommending the necessity for a dues increase by the House of Delegates in 1969. . . ."

Hospital Insurance

In approving Resolution Number 8, the House of Delegates declared MAG policy to be "that hospital insurance should not include the sale of physicians' professional services."

Hospital Privileges

In a lengthy Reference Committee report covering many phases of hospital privileges for practicing physicians, the House of Delegates approved an amended resolution that among other provisos included the following points: (1) That every licensed doctor of medicine of good standing be assured of admitting and

staff privileges in at least one public accredited full facility hospital, (2) That every qualified doctor of medicine on the staff should be permitted to perform all work and procedures for which he is qualified . . . regardless of his association with any specialty group or board, and regardless of employment by or association with persons who are already members of the particular hospital staff, and (3) That each hospital, where feasible, establish a section on the general practice of medicine.

Headquarters Building Expansion

With the benefit of a slide presentation and assistance from an architectural firm, the House of Delegates approved the construction of a 10,000 square foot addition to the MAG Headquarters Office Building to be built on pilings to accommodate a "high rise" building. The structure will provide 180 parking spaces on three levels at an approximate cost of $500,000. The House also authorized Council to proceed with further construction (high rise) as suitable, long term leases become available.

Election of MAG Officers

A resolution calling for the election of MAG officers by the House of Delegates was disapproved. In the same action the House called for the appointment of an Ad Hoc Committee of the Council to study alternative methods of electing MAG officers.

MAG Foundation

To promote the MAG Foundation, the House of Delegates adopted a Reference Committee recommendation that on every possible occasion a full page advertisement be run in the *JMAG* reminding the membership of the Foundation, encouraging county and district medical societies to contribute to the Foundation, and including a statement of the financial condition of the Foundation.

Drug Abuse

In considering a Supplemental Report of the Committee on Mental Health the House of Delegates adopted a recommendation that called for the Medical Association of Georgia and the State Department of Public Health to investigate the extent and percentage of drug abuse in the state, and also to determine what is being done statewide to educate students on drug abuse.

Annual Session Commercial Exhibits

In the report of the Annual Session Committee and in Supplemental Report 2 of the Council, it was recommended that commercial exhibits be terminated beginning with the Annual Session of 1969. This was disapproved by the Reference Committee and the House of Delegates. It was recommended and adopted instead that commercial exhibits be continued as long as financially and technically feasible.

Other Important House Actions

In other actions of the House it was voted to: reaffirm its support of GaMPAC and its leadership; adopt numerous technical amendments to the Constitution and Bylaws; support legislation to give legal immunity to physicians serving on utilization review committees; give a discretionary fund not to exceed $500 to Executive Committee that may be allocated between meetings of Council with an annual limitation of $1,000; and disapproved a resolution recommending that the House of Delegates meet each year in conjunction with the Atlanta Graduate Assembly.

Awards Presented

George H. Alexander, M.D., of Forsyth was awarded the certificate as "General Practitioner of the Year." J. Willis Hurst, M.D., Atlanta, was awarded the

Hardman certificate and cup. Robert B. Greenblatt, M.D., Augusta, took first place in the Scientific Exhibit awards for his exhibit "The Spectrum of Gonadal Dysgenesis." Three GaMPAC awards were given, two for membership given to Upson County and the Fourth District, and a third to Bibb County for financial contribution to the PAC movement.

Officers

The following new officers for the 1968-69 year were elected and/or installed at the 1968 Annual Session: Charles R. Andrews, Jr., Canton, President; John Kirk Train, Savannah, President-Elect; Ronald F. Galloway, Augusta, Second Vice President; Preston B. Ellington, Augusta, Vice Speaker, House of Delegates; and J. Daniel Bateman, Albany, AMA Alternate Delegate.

POSTGRADUATE PROGRAMS IN MATERNAL AND CHILD HEALTH

The Division of Maternal and Child Health of the University of California School of Public Health at Berkeley announces the following postgraduate programs for pediatricians, obstetricians, and other physicians interested in receiving training in the field of Maternal and Child Health. These programs all lead to the degree of Master of Public Health. Tax-exempt fellowship support is available.

Maternal and Child Health. A 9-month program in planning, organizing, and operating comprehensive health services for mothers and children.

Family Planning. A 9-month academic program providing intensive work in family planning as part of the general graduate preparation of maternal and child health specialists.

School Health. A 9-month academic program providing intensive work in school health as part of the general graduate preparation of maternal and child health specialists.

The Multiply Handicapped and Mentally Retarded Child. A 21-month academic and clinical program in planning, organizing, and operating community services for children with multiple handicaps, including mental retardation. This program is primarily for Board-certified or Board-eligible pediatricians, or for physicians on the staff of institutions for the mentally retarded or handicapped children.

Career Development Programs. Three-year academic and residency programs consisting of one year of academic training leading to the degree of Master of Public Health combined with residency training in Pediatrics or Obstetrics-Gynecology. The training emphasizes planning, organization and operation of comprehensive health programs.

Applications are now being accepted for the group entering in July or September 1969. For information write to Helen M. Wallace, M.D., School of Public Health, University of California, Berkeley, California 94720.

FINANCIAL ASSISTANCE FOR NURSING STUDENTS

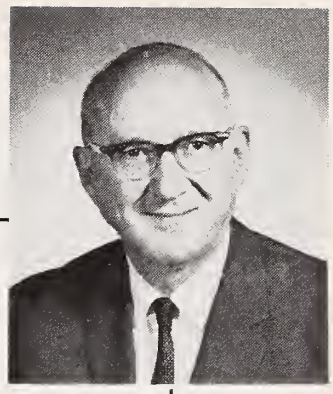
A new financial assistance provision to encourage needy, capable high school students to become professional nurses is now part of the Nurse Training Act.

The Division of Nursing, U.S. Public Health Service, has issued a brochure, "Nursing Educational Opportunity Grants—Information for Schools," describing the new program.

As stated in the Nursing Educational Opportunity Grants brochure, scholarships of up to $800 a year are available for qualified high school graduates of exceptional financial need who are admitted to nursing education programs and make satisfactory progress.

All types of public and nonprofit private nursing education programs—diploma, associate degree, and baccalaureate degree—are eligible to receive Nursing Educational Opportunity Grants for disbursement to students if they meet the accreditation requirements; continue to maintain their own student aid programs at established levels; and work with secondary schools to motivate students toward professional nursing education. Each school which receives such a grant selects the students it will aid and determines the amount of aid each student will receive beyond a minimum of $200.

For information about the five other programs authorized by the Nurse Training Act to aid students and schools of nursing, write to the Division of Nursing, U.S. Public Health Service. Brochures concerning each of these programs, and the new brochure, "Nursing Educational Opportunity Grants—Information for Schools," are also available from the Division, 800 North Quincy Street, Arlington, Virginia 22203.



ANNUAL SESSION

THE 114TH ANNUAL SESSION of the Medical Association of Georgia was concluded May 7, 1968. It is felt that the meeting was quite a success and much credit must be given to Richmond County Medical Society for their fine work and for again hosting our Annual Session. Also, the other people in Augusta who were involved must be thanked for their usual gracious hospitality. Dr. Luther M. Vinton and his Annual Session Committee, of course, have long range planning throughout the year and this requires constant time and thought. Due appreciation of their efforts is often overlooked.

Problem Is Enigma

The problem of Annual Session continues to be quite an enigma. Every one of us needs to realize the many different aspects involved. The Annual Session Committee and the host societies will be tremendously aided if they can have expressions of opinion from all angles. We need to have more general response from individual doctors, component societies of MAG, and the speciality groups.

While it is considered good that in Augusta we had a turnout of approximately 900 people in overall registration (of doctors, auxiliary, and exhibitors), it must be noted that only about five to six hundred doctors were registered. Realizing that our membership is approximately 3,500 doctors, the main trouble with our Annual Session is readily seen. For many years our conventions ran through Wednesday morning and because of the diminishing registration, attempt was made to streamline these meetings hoping that attendance would improve. It would be interesting to know for sure how many of the general membership would prefer a return to the old format whereby we had general sessions with the various speciality speakers dispersed throughout the procedures rather than being concentrated with speciality groups.

Specialists Attend Own Meetings Only

Many of the speciality society members are beginning more and more to attend only that phase of the meeting which involves their own program. Quite a few members attend their special group meeting and never bother to register for the Annual Session.

As an answer to this problem, it has been attempted to arrange meetings so that speciality members can attend their sections on Sunday and Monday, without much general scientific session, and to conclude the Annual Session at noon on Tuesday.

There are two other aspects of the Annual Session which have been considered in the past and are being explored more at the present time. First the possibility of completely separating the times of the business session and the clinical session. The other consideration is eliminating the exhibits sponsored by the drug concerns. (The House of Delegates has indicated its wishes to continue with the exhibits at the present time.)

With these changing times, due consideration must be given to all phases of our Annual Session and attempts must be made to improve attendance. So, for the present, we will be looking forward to a successful meeting in Savannah next year.

Charles R. Andrews Jr M.D.

Charles R. Andrews, Jr., M.D.
President, Medical Association of Georgia

WALLACE REPRESENTATIVES TAKE ADVANCED TRAINING

Wallace Pharmaceuticals has instituted a formal program of education to make its carefully selected field men the most effective information experts possible.

The latest development in this education program is the establishment of a Masters Course, which is an advanced three-year program to instruct its staff in anatomy and physiology, the physiology of disease, the symptoms of disease, and their treatment.

"We believe that representatives of the ethical pharmaceutical industry are full-fledged members of the medical team, which includes physicians, nurses, technicians and pharmacists, and as such, they should be thoroughly trained to perform responsibly, effectively and with total integrity," said W. O. Carcaud, president of Wallace Pharmaceuticals. "If he is to render the maximum assistance to the physician of which he is capable, he must be well versed in patho-physiology and must have a working knowledge of disease, its treatment and the therapeutic and pharmacological action of drugs used in treatment."

The Masters Course, which almost the entire Wallace field force of 350 has chosen to take, will first cover such broad areas as the cell, urinary fluids, blood, cardiovascular disease, respiration, neuro-muscular disorders, the special senses, gastrointestinal complaints and endocrinology.

The second section of the three-year course will concern itself with therapeutics and review and the normal and abnormal processes of the mind.

Texts will include outstanding reference works, such as "Pharmacological Principles of Medical Practice," by Krantz and Karr. Five Wallace representatives in Georgia have elected to take the Masters Course. They are: Joseph L. Brown, Jr., Charles Culpepper, James G. Watson, Jr., Winn Hines and Eugene N. Bruker.

ELECTROENCEPHALOGRAPHY COURSE PLANNED FOR SAN FRANCISCO

A continuation course in Clinical Electroencephalography will be held September 9-11, 1968, in San Francisco, California. The course is designed as a basic review of the applications of the EEG to clinical medical practice, and is sponsored by the American EEG Society (aided by a grant from the National Center for Chronic Disease Control, U.S. Public Health Service).

The faculty will include Drs. Reginald G. Bickford, Rochester, Minn.; David D. Daly, Dallas, Tex.; Robert J. Ellingson, Omaha, Neb.; Eli S. Goldensohn, New York, N.Y.; Charles E. Henry, Cleveland, Ohio; Peter Kellaway, Houston, Tex.; John R. Knott, Iowa City, Iowa; Michael G. Saunders, Winnipeg, Canada; Daniel Silverman, Philadelphia, Pa.; Richard D. Walter, Los Angeles, Calif.

Inquiries about further details of the course or registration procedure should be addressed to Dr. Donald W. Klass, EEG Course Director, Mayo Clinic, Rochester, Minnesota 55901.

CRYOSURGERY GROUP FORMED, PLANS QUARTERLY JOURNAL

The first issue of the *Journal of Cryosurgery,* the official quarterly of *The Society for Cryosurgery,* will appear in June 1968. Membership for cryosurgery is open to all individuals interested in dermatology, gynecology, neurosurgery, oncology, otolaryngology, urology and others. Manuscripts are now being solicited for the second and subsequent issues. Inquiries and manuscripts should be sent to: John G. Bellows, M.D., Editor, 30 N. Michigan Avenue, Chicago, Illinois 60602.

THERAPEUTIC ABORTION LAW—EXPLANATION OF REQUIRED FORMS

JOHN L. MOORE, JR., ***and***
TRAMMELL E. VICKERY, ***Atlanta****

THE 1968 GENERAL ASSEMBLY of Georgia passed a highly significant law (Act No. 1265) substantially changing prior law in the areas of Abortion, Foeticide and Infanticide. The Governor of Georgia allowed the Act to become law without his signature. The Act provides for the lawful performance of abortions in carefully prescribed and specifically documented cases hereinafter discussed.

Requirements Outlined

The new Act is very specific as to the reasons for which abortions may be considered necessary, and therefore performed legally under the law of Georgia. These reasons are as follows:

1. A continuation of the pregnancy would endanger the life of the pregnant woman or would seriously and permanently injure her health; or
2. The fetus would very likely be born with a grave, permanent, and irremediable mental or physical defect; or
3. The pregnancy resulted from forcible or statutory rape.

The statute is very specific as to the documentation which must occur before the performance of the operation of abortion and as to the filing of such information. This language is of such great importance that it is set out here in full:

26-1106. Exceptions; opinion.

(b) No abortion is authorized or shall be performed under this Section unless each of the following conditions is met:

(1) The pregnant woman requesting the abortion certifies in writing under oath and subject to the penalties of false swearing to the physician who proposes to perform the abortion that she is a bona fide legal resident of the State of Georgia.

(2) The physician certifies that he believes the woman is a bona fide resident of this State and that he has no information which should lead him to believe otherwise.

(3) Such physician's judgment is reduced to writing and concurred in by at least two other physicians duly licensed to practice medicine and surgery pursuant to Chapter 84-9 of the Code of Georgia of 1933, as amended, who certify in writing that based upon their separate personal medical examinations of the pregnant woman, the abortion is, in their judgment, necessary because of one or more of the reasons enumerated above.

(4) Such abortion is performed in a hospital licensed by the State Board of Health and accredited by the Joint Commission on Accreditation of Hospitals.

(5) The performance of the abortion has been approved in advance by a committee of the medical staff of the hospital in which the operation is to be performed. This committee must be one established and maintained in accordance with the standards promulgated by the Joint Commission on the Accreditation of Hospitals, and its approval must be by a majority vote of a membership of not less than three members of the hospital's staff; the physician proposing to perform the operation may not be counted as a member of the committee for this purpose.

** Prepared at the request of The Medical Association of Georgia and the Georgia Hospital Association. Mr. Moore is a member of the firm of Alston, Miller & Gaines, general counsel to the Medical Association of Georgia. Mr. Vickery is a member of the firm of Jones, Bird & Howell, general counsel to the Georgia Hospital Association.*

(6) If the proposed abortion is considered necessary because the woman has been raped, the woman makes a written statement under oath, and subject to the penalties of false swearing, of the date, time and place of the rape and the name of the rapist, if known. There must be attached to this statement a certified copy of any report of the rape made to any law enforcement officer or agency and a statement by the solicitor general of the judicial circuit where the rape occurred or allegedly occurred that, according to his best information, there is probable cause to believe that the rape did occur.

(7) Such written opinions, statements, certificates, and concurrences are maintained in the permanent files of such hospital and are available at all reasonable times to the solicitor general of the judicial circuit in which the hospital is located.

(8) A copy of such written opinions, statements, certificates, and concurrences is filed with the Director of the State Department of Public Health within ten (10) days after such operation is performed.

(9) All written opinions, statements, certificates and concurrences filed and maintained pursuant to paragraphs (7) and (8) of this subsection shall be confidential records and shall not be made available for public inspection at any time.

The Act also contains provisions allowing the solicitor general of the judicial circuit in which the abortion is to be performed or any person who would be a relative of the child within the second degree of consanguinity to file court proceedings to stop the performance of the operation of abortion. In such an action, both the patient and the physician who proposes to perform the abortion would be made parties to the action, and it is highly likely that the hospital in which the abortion is to be performed would be made a party as well. The court is to hear the matter expeditiously and if it adjudges that such an abortion would violate the constitutional or other legal rights of the fetus, the court so declares and restrains the physician from performing the abortion.

The Act further states that if the abortion is performed in compliance with Section 26-1106 of the Code of Georgia, no action arises for the death of the fetus. Similarly, the performance of the abortion is not a crime.

Failure to Comply

It is very important for patients, physicians, and hospitals to realize that the performance of an abortion without complete compliance with all of the technicalities of Section 26-1106 is a serious crime. If the abortion is criminally performed before the child is "quick," the physician may be imprisoned for from one to ten years. If, on the other hand, the fetus is "quick" at the time of the abortion, death or imprisonment for life, as the jury may recommend, may be imposed upon the physician. In addition, substantial civil penalties in the form of damage awards against all who participate in an unauthorized abortion are a distinct possibility.

IT, THEREFORE, CANNOT BE TOO STRENUOUSLY EMPHASIZED THAT EXACT COMPLIANCE WITH THE PAPERWORK IMPOSED BY THE STATUTE IS ABSOLUTELY ESSENTIAL.

A set of forms which would appear to the writers to comply with the statute is set out at the end of this Article. If exact compliance with the statute cannot be had, it is strongly emphasized again that no physician or hospital should be involved in the performance of the operation of the abortion. It would be extremely foolish to proceed with an abortion on the theory that the paperwork can be done at a later time. Any person who proceeds on that basis will do so at substantial risks.

Statutory Prerequisites

The following basic requirements are required by the statute before an abortion can be performed:

1. The patient must be a resident of the State of Georgia. If the physician has any information which "should" lead him to believe otherwise, he will commit a crime if he performs any abortion no matter what the cause.

2. There must be the requisite finding of necessity for the abortion in the statutory language quoted above in this Article. Any one of the three causes is sufficient ground for the performance of the operation of abortion.

3. The operation must be performed in a hospital licensed by the State Board of Health and accredited by the Joint Commission on Accreditation of Hospitals. The performance of an abortion of any kind at any other place in the State of Georgia would constitute a crime.

4. The Abortion Committee of the hospital must act in favor of the abortion in advance of its performance. There must be at least three members of the Hospital Abortion Committee and the physician to perform the abortion may not be counted as a member of the Committee for that purpose.

Comment

It seems to the writers that the generality inherent in the statutory reasons for abortion will cause some difficulty to practicing physicians. Prior practice ought to be sufficient to establish reasonable standards governing the first necessity for abortion—the life or health of the pregnant woman.

On the other hand, a more difficult standard is stated if the abortion is performed because of the likely defect in the fetus. The statute reads:

> "The fetus would very likely be born with a grave, permanent, and irremediable mental or physical defect . . ."

The problem will come with the words "would very likely." In terms of scientific knowledge, would the fetus of a woman who had Rubella in the first trimester of pregnancy "very likely be born with grave, permanent, and irremediable mental or physical defect"? As these writers understand it, the percentage chance of all such cases is not a majority. On the other hand, medically an abortion in such a case might make sense especially if there are already other children of the marriage and if the patient is reasonably young. It is suggested that some standard ought to be developed on a state-wide basis in The Medical Association of Georgia as to a proper compliance with this statutory language.

If the cause is rape, the physician, under the terms of the statute, seems to have less of a role in deciding whether to perform the abortion. The statute provides requisite statements for the patient and solicitor general of the judicial circuit. Apparently, the physician is not obligated to make any separate finding as to the possibility that the pregnancy is caused by the rape. If, on the other hand, the physician has scientific cause to believe that the pregnancy was not the result of forcible or statutory rape he could not, of course, give the necessary statement required of him as to the stated necessity for the abortion. Put more simply, no physician could participate in an abortion because it resulted from rape if he does not believe that the pregnancy resulted from the rape.

Who Is a Bona Fide Legal Resident of the State of Georgia?

No legal question is more difficult to determine with absolute certainty than the question on a given date as to whether a person is a "resident" of a particular State. Theoretically, a person becomes a resident of a State on the day she moves to the State with an intention to reside there permanently and with no present intention of moving to another State. However, such a standard which is used in some States to determine residency for questions of divorce, does not seem to be a sufficient standard to protect physicians proposing to perform abortions in this State.

In order for the physician to be safe in accepting the patient's affidavit and in executing his own, the the writers of this article suggest that the physician must have asked the patient the three following questions. The patient must have answered all three questions in the affirmative. The physician must have no knowledge which should cause him to believe otherwise. The three questions are:

1. Have you resided in Georgia for the last three months?
2. Does your family now reside in Georgia on a permanent basis?
3. Do you intend to reside permanently in Georgia?

If the patient answers any of the three questions in the negative, or if the physician has any information which should cause him to question the patient's answer to any of the questions, the physician should either decline to perform the operation of abortion or consult legal counsel before proceeding further with the documentation and performance of the operation.

Permissive Legislation

It should be recognized that the new Therapeutic Abortion Law is permissive. No physician or hospital is required to perform abortions even though authorized by the statute. Section 26-1106(e) makes it absolutely clear that nothing requires the hospital to admit any patient for the purpose of performing an abortion nor is the hospital required to appoint a committee to approve the performance of the procedure. If any physician or person associated with a hospital states in writing an objection to the abortion on moral or religious grounds, no such person shall be required to participate in the medical procedures resulting in the abortion. The refusal of any such person to participate in the abortion may not form the basis of any claim for damages on account of the refusal or for any disciplinary or recriminatory action against such person. For example, it would be unlawful to discipline a staff member who refused to serve as a member of an abortion committee on moral or religious grounds stated in writing.

Conclusion

Beginning with the April effectiveness of the new Abortion Law, therapeutic abortions must be performed, if at all, under the provisions of the new law.* It will not be sufficient to follow old procedure. If a woman is pregnant and another operation is performed which will have the possible effect of aborting the woman, it would be advisable to comply with the provisions of the abortion statute in advance of performing the procedure.

** Some emergency situations may arise where absolute compliance with the statute becomes difficult. Legal principles dealing with emergencies may become applicable, but it is suggested that such individual situations be discussed with legal counsel before proceeding.*

PATIENT'S AFFIDAVIT [To be executed in duplicate by the patient before performance of operation of abortion]

Date ..... Time ..... A.M. P.M.

The undersigned patient, being first duly sworn, deposes and states as follows:

1. The undersigned patient has requested Dr. ....., and assistants of his choice, to perform upon her the operation of abortion for the following reason: [Strike out any inapplicable language]

(a) A continuation of the pregnancy would endanger the life of the undersigned patient or would seriously and permanently injure her health; or

(b) The fetus would very likely be born with a grave, permanent, and irremediable mental or physical defect; or

(c) The pregnancy resulted from forcible or statutory rape.

2. Understanding that this statement is made under oath and subject to the penalties of false swearing, the undersigned patient hereby certifies to the physician named above who proposes to perform the operation of abortion that she is a bona fide legal resident of the State of Georgia.

3. [If the proposed operation of abortion is considered necessary because the patient has been raped, complete the following.] Understanding that this statement is made under oath and subject to the penalties of false swearing, the undersigned patient hereby certifies that she was raped on ..... (Date)

at ..... A.M. P.M. (Time) and at ..... (Place of the Rape)

and that the name of the rapist is ..... (if known; if unknown, state unknown).

4. It has been explained to the undersigned patient, and she understands, that this operation is intended to result in the destruction of the fetus although this result has not been guaranteed. The undersigned patient has been informed by the physician above named of the nature of the operation to be performed, the risks involved, and the possibility of complications. The undersigned patient desires the performance of such operation, assumes the risks and consequences involved, and authorizes the performance of said operation at ..... Hospital which is a hospital licensed by the State Board of Health and accredited by the Joint Commission on Accreditation of Hospitals.

5. The undersigned patient hereby authorizes the physician and hospital above named, or either of them, to dispose of the fetus. The undersigned patient hereby authorizes the filing of this Statement with the Director of the State Department of Public Health and the keeping of this Statement in the permanent files of the hospital above named where it will be made available at all reasonable times to the Solicitor General of the judicial circuit in which said hospital is located but will otherwise not be made available for public inspection at any time.

6. This Statement, which has been executed in duplicate, is intended to be the statement required of the pregnant woman by Section 26-1106 of the Code of Georgia of 1933, as amended.

.....
Patient

Personally appeared before the undersigned Notary Public ....., (Patient) who, after being duly sworn, deposes and says that she has read and understands the foregoing affidavit; that the facts contained therein are true; and that she freely and voluntarily executes the same without coercion of any kind by any person.

.....
Notary Public
My Commission Expires .....

CERTIFICATE OF PHYSICIAN TO PERFORM OPERATION OF ABORTION

[To be executed in duplicate before performance of operation of abortion.]

Date ..... Time ..... A.M. P.M.

The undersigned Medical Doctor, being a doctor of medicine duly licensed to practice medicine and surgery pursuant to Chapter 84-9 of the Code of Georgia of 1933, as amended, hereby certifies that:

1. The undersigned believes that ..... (Name of Patient) ..... is a bona fide resident of the State of Georgia. The undersigned certifies that he has no information which should lead him to believe otherwise.

2. The undersigned has made a personal medical examination of the patient above named and, in his judgment, the performance of an operation of abortion is necessary because of one or more of the following reasons (strike out any inapplicable language):

(a) A continuation of the pregnancy would endanger the life of the above named patient or would seriously and permanently injure her health; or

(b) The fetus would very likely be born with a grave, permanent, and irremediable mental or physical defect; or

(c) The pregnancy resulted from forcible or statutory rape.

3. The operation of abortion is to be performed in ..... Hospital which is a hospital licensed by the State Board of Health and accredited by the Joint Commission on Accreditation of Hospitals.

4. The undersigned has explained to the patient named above that the operation of abortion is intended to result in the destruction of the fetus although that result has not been guaranteed. The undersigned has informed the patient named above of the nature of the operation to be performed, the risks involved, and the possibility of complications.

5. The undersigned physician authorizes the filing of this Certificate with the Director of the State Department of Public Health and understands that one executed copy thereof will be maintained in the permanent files of the above named hospital and made available at all reasonable times to the Solicitor General of the judicial circuit in which said hospital is located.

6. This Certificate, which has been executed in duplicate, is intended to be the statement required of the physician to perform the operation of abortion by § 26-1106 of the Code of Georgia of 1933, as amended.

.....
(Physician)

Personally appeared before the undersigned Notary Public ..... who, after being
(Physician)
duly sworn, deposes and says that the facts stated in the foregoing Certificate are true; and that the opinions expressed therein he verily believes to be true.

.....
Notary Public

My Commission Expires .....

WRITTEN STATEMENT OF CONCURRENCE BY TWO OTHER PHYSICIANS

[To be executed in duplicate by the concurring physicians before performance of operation of abortion.]

A.M.
Date ..... Time ..... P.M.

The undersigned physicians, each of whom is duly licensed to practice medicine and surgery pursuant to Chapter 84-9 of the Code of Georgia of 1933, as amended, certify and state that:

1. Each of us has made a separate personal medical examination of ..... In the
(Name of patient)
judgment of each of us and both of us the said woman is pregnant and an abortion is necessary because of one or more of the reasons enumerated below (strike out any inapplicable language):

(a) A continuation of the pregnancy would endanger the life of the above named patient or would seriously and permanently injure her health; or

(b) The fetus would very likely be born with a grave, permanent, and irremediable mental or physical defect; or

(c) The pregnancy resulted from forcible or statutory rape.

2. We, and each of us, concur in the judgment of the physician above named that the performance of the operation of abortion on the patient above named is necessary because of the reasons contained in the statement of the physician to perform the operation of abortion carried above in this Certificate.

3. Each of the undersigned has explained to the patient named above that the operation of abortion is intended to result in the destruction of the fetus although that result has not been guaranteed. Each of the undersigned has informed the patient named above of the nature of the operation to be performed, the risks involved, and the possibility of complications.

4. Each of us authorizes the filing of this Certificate with the Director of the State Department of Public Health and understands that one executed copy thereof will be maintained in the permanent files of the above named hospital and made available at all reasonable times to the Solicitor General of the judicial circuit in which said hospital is located.

5. This Certificate, which has been executed by each of us in duplicate, is intended to be the statement required of the concurring physicians by § 26-1106 of the Code of Georgia of 1933, as amended.

.....
(Physician)

.....
(Physician)

Personally appeared before the undersigned Notary Public ..... and
(Physician)
....., each of whom, after
(Physician)
being duly sworn, deposes and says that each of them concurs in the above statement; that the facts stated in the foregoing Certificate are true; and that the opinions expressed therein are verily believed to be true.

.....
Notary Public

My Commission Expires .....

CERTIFICATE OF ACTION OF ABORTION COMMITTEE OF HOSPITAL

A.M.
Date ..... Time ..... P.M.

The undersigned physician, acting as .....
(State Office)

of the ..... Committee of the Medical Staff of the ..... Hospital located in ....., Georgia, certifies as follows:

1. The ..... Committee is a Committee of the Medical Staff of the above hospital. The Committee is established and maintained in accordance with the standards promulgated by the Joint Commission on the Accreditation of Hospitals.

2. At a valid meeting of such Committtee held at ..... o'clock .... .M. on the .... day of ....., 196.., the performance of the operation of abortion on .....
(Name of Patient)
by ..... at
(Name of Physician to Perform Operation)
..... was approved by a
(Name of Hospital)
majority vote of the Committee membership of not less than three members of the Staff of the hospital. In computing the majority vote and the number of members of the Committee, ...
..... was not
(Name of Physician to Perform Operation)
counted as a member of the Committee.

.....
(Physician)

CERTIFICATE OF SOLICITOR GENERAL AS TO OCCURRENCE OF RAPE

A.M.
Date ..... Time ..... P.M.

The undersigned ....., Solicitor General of the ..... Judicial Circuit of the State of Georgia, hereby certifies as follows:

1. Attached to this certificate and made a part hereof as Exhibit A hereto is a certified copy of the report of the rape upon .....
(Name of Patient)
made to .....
(Name of Law Enforcement Officer or
.....
Agency to Whom Report Made)

2. The rape described in such report allegedly occurred in the judicial circuit of which the undersigned is Solicitor General.

3. Based on investigations of such report of rape, made by me and by my office, according to my best information, there is probable cause to believe that the rape did occur.

4. This statement, which has been executed in duplicate, is intended to be the statement required of the Solicitor General in subparagraph (6) of subsection (b) of Section 22-1106 of the Code of Georgia of 1933, as amended.

5. The undersigned hereby authorizes the filing of a copy of this Certificate with the Director of the State Department of Public Health and understands that a copy hereof will be kept in the permanent files of the hospital in which the abortion of the above named patient will be performed and will be available at all reasonable times to the Solicitor General of the judicial circuit in which the hospital is located but shall not be made available for public inspection otherwise.

.....
Solicitor General
..... Judicial Circuit

LETTER OF TRANSMITTAL TO DIRECTOR OF STATE DEPARTMENT OF PUBLIC HEALTH

....., 196..

John H. Venable, M.D.
Director, State Department
of Public Health
47 Trinity Avenue, S.W.
Atlanta, Georgia 30334

Dear Sir:

As required by Section 26-1106(b)(8) of the Code of Georgia of 1933, as amended, we file with you the following documents relating to the performance of the operation of abortion upon .....
..... which operation
(Name of Patient)
was performed at the hospital named below on ....
(Insert
.....
date of Operation which must not be more than 10 days
.....:
before the date of this letter)

1. The Statement of the Patient required by Section 26-1106(b)(1);

2. The Certificate of the Physician performing the operation of abortion concurred in by two other physicians as required by Section 26-1006 (b)(2) and (3);

3. The Certification of Action of the .....
..... Committee of this hospital as required by Section 26-1106(b)(5);

4. If required, the Statement of the Solicitor General of the Judicial Circuit where the rape allegedly occurred as required by Section 26-1106(b)(6).

I shall appreciate your acknowledging receipt of the enclosures so that our file will show complete compliance with the provisions of Georgia law.

Very truly yours,
..... Hospital
By .....

A fetal death certificate is required in all cases of abortion under a different Georgia law (Section 88-1716). Information and forms may be obtained from the Georgia Department of Public Health.

NEW MEMBERS

Averitt, Thomas E., M.D. Active—McDuffie	P.O. Box 408 Thomson, Georgia 30824
Bozzini, Miguel A., M.D. Associate—Fulton	80 Butler Street, S.E. Atlanta, Georgia 30305
Cobham, I. G., M.D. Active—Fulton	2910 Paces Lake Dr., N.W. Atlanta, Georgia 30327
Cureton, Richard K., M.D. Active—Walker-Catoosa-Dade	Hutcheson Hospital Fort Oglethorpe, Georgia 30742
Dennis, Allen J., Jr., M.D. Active—Richmond	Talmadge Memorial Hospital Augusta, Georgia 30902
Evans, Donald C., M.D. Active—Bartow	210 W. Main St. Cartersville, Georgia 30120
Flanagan, James C., M.D. Active—Fulton	Emory University Medical School Atlanta, Georgia 30322
Gomez, Julian R., M.D. Active—Fulton	3400 Peachtree St., N.E. Atlanta, Georgia 30326
Gonzalez, Arturo, M.D. Active—Mitchell	28 S. Ellis Street Camilla, Georgia 31730
Hemphill, John R., M.D. Active—Hall	700 S. Enota Drive, N.E. Gainesville, Georgia 30501
Lewis, Edward L., Jr., M.D. Active—Crawford W. Long	1077 Baxter Street Athens, Georgia 30601
Miller, William A., M.D. Active—Georgia Medical Society	Memorial Medical Center Savannah, Georgia 31401
Ordonez, Luis J., M.D. Active—Walker-Catoosa-Dade	P.O. Box 205 Trenton, Georgia 30752
Ponde de Leon, A. I., M.D. Active—Fulton	3400 Peachtree St., N.E. Atlanta, Georgia 30326
Venable, Robert N., M.D. Active—Fulton	403 15th Ave. Cordele, Georgia 31015

SOCIETIES

Members of the **DeKalb County Medical Society** heard Dr. Charles A. Waldron, Professor and Chairman, Department of Pathology, Emory University School of Dentistry, speak on "Oral Leukoplakia, Recognition and Management" at their April meeting.

The **Fulton County Medical Society** was co-sponsor along with the Atlanta YWCA and the American Social Health Association of five health forums held in April for the general public. Heart disease, mental illness, drug abuse, venereal disease and cancer of the breast were the topics of discussion.

The **Georgia Medical Society's** lively monthly meetings were spotlighted in an article entitled "Savannah Finds Cure for Ho-Hum Syndrome" in a recent issue of the A.M.A.'s bi-monthly magazine *PR Doctor*. At the April meeting, members of the society heard J. Gordon Barrow, M.D., of Atlanta, Director of the Georgia Regional Medical Program, speak on "The Crystal Ball —Medicine in the Next 25 Years."

The **Hall County Medical Society** has submitted a proposal to the county commissioners asking that they require all emergency vehicles to "comply with the usual traffic laws while traveling in the county."

Members of the **Laurens County Medical Society** heard Dr. Hans Peters, a pathologist from St. Francis Hospital in Columbus, speak about the influence of basic science on clinical medicine at their March meeting.

The **Muscogee County Medical Society** and the **Third District Medical Society** sponsored a full-day Medical Surgical Symposium with an outstanding guest faculty in April.

A. M. Phillips, Jr., discussed congenital orthopedic problems at the April meeting of the **Peach Belt Medical Society** which met at the Houston Lake Country Club.

The **Sixth District Medical Society** held its spring meeting in Thomaston, April 17, with excellent attendance. Comptroller-General James L. Bentley, a native of Thomaston, was the guest speaker. State Representative Johnny Caldwell of Upson County was also a guest. Dr. Braswell E. Collins, society president, presided. Dr. Norman Gardner is the society's secretary. The summer meeting will be held in mid-July in Newnan.

The one-day symposium on clinical medicine and surgery sponsored by the **South Georgia Medical Society** in cooperation with the **Eighth District Medical Society** and Lederle Laboratories, drew over 100 doctors from the south Georgia-north Florida area.

Mr. Stan Berge, Assistant Director of the YMCA in Albany, presented a program on physical fitness to

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members of the **Sumter County Medical Society** at their regular meeting in March.

The **Thomas-Brooks County Medical Society** held its quarterly meeting March 21 at the Quitman Garden Center. Dr. Thomas Malone of Thomasville turned the gavel over to the new president, Dr. Donald McKenzie of Thomasville. Dr. Granger Osborne of Thomasville is the new secretary-treasurer. The program for the evening was a report on ear problems by Dr. Briggs Smith of Valdosta.

PERSONALS

First District

Martha Cole Gordy has been named by the Chatham County Hospital Authority as director of education in internal medicine at Memorial Medical Center. She succeeds **Curtis H. Carter,** who became associate dean of the Medical College of Georgia on May 1.

Thomas Yeh, director of education in surgery at Memorial Medical Center in Savannah, has been elected to fellowship in the American College of Cardiology.

Second District

Two Sylvester physicians, **Frederick L. McLean** and **Robert T. Morgan,** have been elected to active membership in the American Academy of General Practice. **Warren C. Baxley** of Blakely has been re-elected to active membership.

Fourth District

"This Is Your Life" was the theme of the Doctor's Day dinner given for **R. L. Carter** of Thomaston by the Upson County Medical Society's Woman's Auxiliary in April. The script reviewed Dr. Carter's more than 50 years of practice.

Fifth District

William W. Moore of Atlanta spoke on epilepsy at the meeting of the Greater Atlanta Chapter, Epilepsy Foundation of America, held April 24.

Wood Lovell, chief of the Department of Orthopedic Surgery at Georgia Baptist Hospital and surgeon-in-chief at the Scottish Rite Hospital, was director of a postgraduate course on treatment of trauma and disease in children which was held in Atlanta recently under the sponsorship of the Committee on Injuries of the American Academy of Orthopedic Surgeons.

Bruce Logue recently presented a talk at the meeting of the American College of Physicians in Boston entitled "Diagnosis and Treatment of Pericardial Effusion with Steroids and/or Diuretics."

J. Willis Hurst has been appointed to the National Advisory Heart Council.

Edwin C. Evans was recently elected president of the Atlanta Blue Shield. Other new officers are **Albert A. Rayle,** vice president and **Haywood N. Hill,** secretary. **Edward L. Bosworth** was re-elected treasurer.

R. C. Williams, Sr., was recently presented a Distinguished Service Award by the Georgia Hospital Association.

Sixth District

Thomas L. Ross, Jr., of Macon was a recipient of the American Heart Association's Award of Merit presented at a luncheon of the Association's Board of Trustees held in Baltimore in January.

Seventh District

W. Blair Hudgins began the practice of medicine May 1 at the Fairmount Clinic.

Hugh S. Colquitt of Marietta is one of 525 physicians from the American Academy of Pediatrics and other child health groups selected to evaluate the medical aspects of the Head Start programs throughout the country.

Eighth District

Dr. and Mrs. Jerry G. Purvis of Valdosta attended the 36th Annual Assembly of the Southeastern Surgical Congress held in Washington, D.C., in April.

Tenth District

D. N. Thompson of Elberton, who has completed over 60 years of medical practice, was honored by the Elberton Rotary Club on "Dr. Thompson Day" in April.

Walter G. Rice of Augusta, dean of the School of Medicine at the Medical College of Georgia, has been named to the National Board of Medical Examiners. Earlier this year he was named by Surgeon General William H. Stewart to the Public Health National Advisory Council on Medical, Dental, Optometric and Pediatric Education.

Robert G. Ellison of Augusta spoke to the Augusta Kiwanis Club in April on the surgical aspects of treating heart disease.

DEATHS

Farris Talmadge McElreath, Jr.

Farris Talmadge McElreath, Jr., 44, a prominent Washington County doctor who lived in Tennille, died April 4, 1968.

Dr. McElreath graduated from Emory University and the Medical College of Georgia. He served his internship at University Hospital in Augusta.

He was an active member of Tennille Methodist Church, a member of the Tennille Rotary Club, Tennille Lodge No. 256 F. & A.M., and Alpha Tau Omega and Alpha Kappa Kappa fraternities. He was a past president of the Washington County Medical Society, was chief of staff of Memorial Hospital of Washington County, a former member of the Tennille Elementary School Board, the Tennille City Council and the County Health Board.

Dr. McElreath is survived by his wife, Mrs. Marjorie Jordan McElreath; his son, Farris Talmadge McElreath, III; and three daughters, Marjorie Elizabeth, Mary Susan and Deborah Jean, all of Tennille, and his mother, Mrs. F. T. McElreath, Sr., and brother, William C. McElreath, both of Wadley.

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THE MONTH IN WASHINGTON

The federal government has established a new agency and appointed two new advisory committees in the health care field.

The new agency is the National Center for Health Services Research and Development. The committees are:

1. The Medical Assistance Advisory Council that will advise the secretary of Health, Education and Welfare on matters relating to federal-state medical aid programs.

2. A panel to give the social security commissioner advice on experiments to find new methods of reimbursing hospitals and physicians for health care under medicare and other federal health programs.

Health, Education and Welfare spokesmen said the new center will work with universities, industry, hospitals, practitioners and research institutions to seek new ways of delivering health care. It was authorized by Congress last year at the Johnson administration's request.

"The ultimate goal of the center is to aid practitioners and institutions involved in health services to improve the distribution and quality of services and to make the best possible use of manpower, funds, and facilities," said Dr. Philip R. Lee, assistant HEW secretary for Health and Scientific Affairs.

Director of the center, which is under the newly created Health Services and Mental Health Administration, is Dr. Paul J. Sanazaro, who had directed education and medical care research for the Association of American Medical Colleges since 1962.

HEW said the advisory council would be consulted on program development and practical operational problems involved in Medicaid (Title XIX of Social Security).

The Social Security Administration said the reimbursement panel would review proposals for experiments submitted by institutions and individuals in the health care and health insurance fields. After such reviews, it will be asked to recommend the ones it believes to have the greatest potential.

* * *

The American Medical Association urged that Congress appropriate maximum amounts for support of medical education.

The AMA position was outlined by Dr. C. H. William Ruhe, director of the AMA's division of medical education, at a hearing of a House appropriations subcommittee.

"An urgent need exists in this country for more physicians to meet the health care needs of the American public. This need can only be met effectively by a major increase in the capacity of American medical schools to educate more physicians."

Dr. Ruhe noted that Federal aid to medical schools under the proposed Health Manpower Act of 1968 would not become available before 1970. Therefore, he said efforts must be made to secure the essential immediate increase in financial support through increased appropriations under existing law. He listed the Health Professions Educational Assistance Act, the Health Research Facilities Construction Act, the Medical Act, and the general research support authority of the National Institutes of Health.

Gov. Nelson Rockefeller of New York and two other witnesses at a Senate subcommittee hearing supported national compulsory health insurance as a solution of the problem of rising health care costs.

But Wilbur J. Cohen, acting secretary of Health, Education and Welfare who favored the plan 20 years ago, said he now believes the government should move on other fronts. He said it would be difficult—a "monumental task"—at this time to achieve a workable and acceptable program of compulsory national health insurance. He did not foresee the United States following the pattern of European nations in adopting a monolithic central health system for the entire nation. He said this country is too large for a single plan but that the benefits under any various plans adopted should be relatively uniform for all Americans.

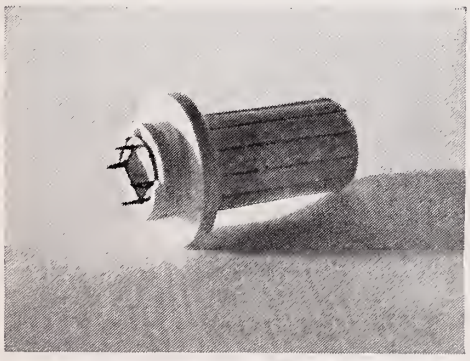
Cohen said first priority now should be given maternal and child health programs. He listed as other "must" programs the expansion of medical manpower and health facilities and the continued investment in health research.

Sen. Abraham Ribicoff (D., Conn.), chairman of the subcommittee holding hearings on health care costs, also said that the emphasis now should be on more immediate solutions. He said that his experience with the fight over medicare had convinced him that it would be a long time before Congress would accept compulsory national health insurance.

From the Washington Office
American Medical Association
May 6, 1968

To fight TB-find it first!

Make tuberculin testing routine with every physical examination.



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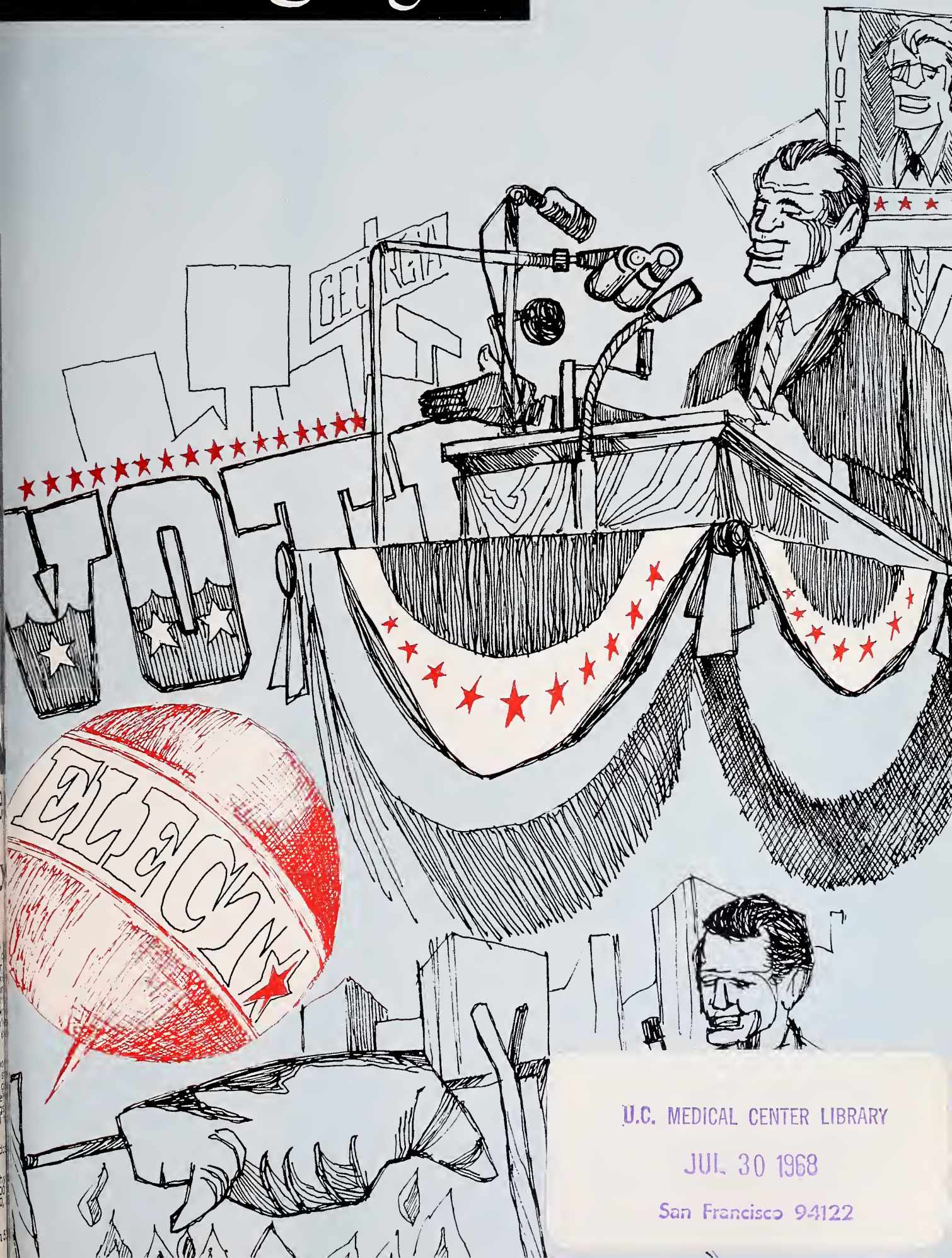

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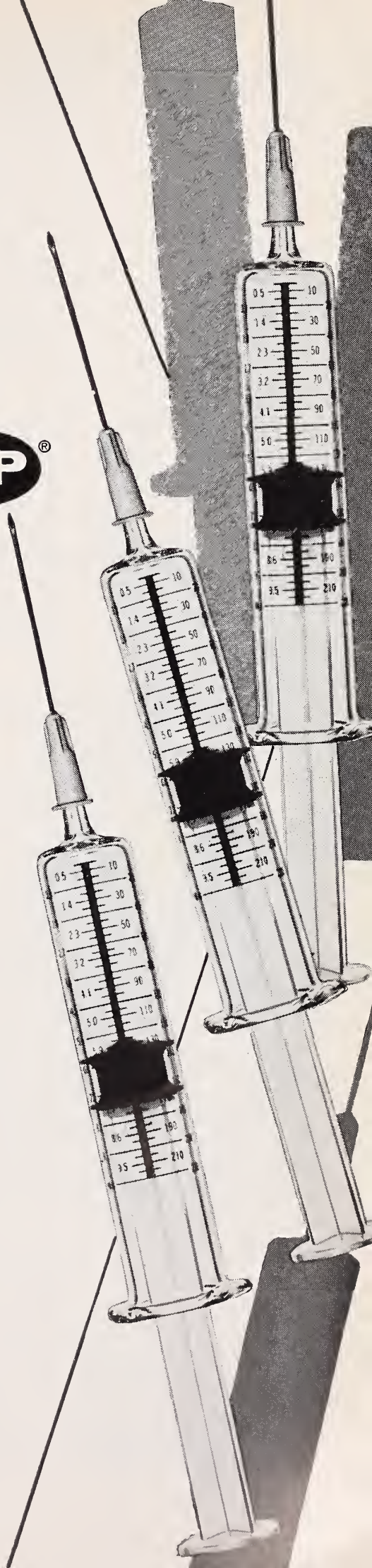

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Cover

The biennial ritual of bunting, barbeque and thundering oratory fill the American landscape as the nation braces for the coming elections. In the All American spirit of Independence Day we dedicate this cover.

Design by Stein Typography Shop, Atlanta.

JOURNAL OF THE MEDICAL ASSOCIATION Georgia

The facilities of the world's largest biomedical library are described.

The Physician and the National Library of Medicine

LEONARD KAREL, PH.D.,* *Bethesda, Maryland*

When the National Library of Medicine was established in 1836 as the Library of the Surgeon General's Office (U.S. Army), the Surgeon General was authorized to spend $150 for medical literature. Today the library, located at Bethesda, Maryland, near Washington, in a five-story contemporary building which it has occupied since 1962, is regarded as the world's largest in biomedicine. Among its holdings of 1,300,000 items, in seventy languages, are 315,000 monographs; 310,000 bound journal volumes; 285,000 theses; 168,000 pamphlets; and 4,500 reels of microfilm.

The library provides 175,000 interlibrary loans annually, and of these, 160,000 are photocopies of journal articles not available at the requesting local library. Reference personnel answer 10,000 personal inquiries, 10,000 phone inquiries, and 2,000 mail inquiries each year. Requests for 100,000 library items are made by 25,000 to 30,000 persons who use the reading room each year.

Numerous Library Publications

The library is a major publisher of biomedical bibliographies; e.g., *Index Medicus, Cumulated Index Medicus, Bibliography of Medical Reviews, Biomedical Serials 1950-1960, Bibliography of the History of Medicine,* and *NLM Current Catalog.* Among other library publications are *Medical Subject Headings,* the thesaurus for *Index Medicus; List of Journals Indexed in Index Medicus; National Library of Medicine Classification;* and *Russian Drug Index.*

Known for 86 years as the Library of the Surgeon General's Office, the library was developed as both a national and an international resource by Dr. John Shaw Billings, librarian from 1865 to 1895. In 1922, it was renamed the Army Medical Library and in 1952 was again renamed, the Armed Forces Medical Library. In 1956, under legislation introduced by Senators Lister Hill of Alabama and John F. Kennedy of Massachusetts, it was transferred to the Public Health Service, Department of Health, Education and Welfare, and named the National Library of Medicine.

Established by Act of Congress

The library was established by the Congress of the United States to assist in the advancement of medical and medically related sciences by the collection, dissemination, and exchange of scientific and other information important to the progress of medicine and of public health.

Towards fulfillment of its mission the library (1) acquires and preserves books, periodicals, films,

* *Dr. Karel is Special Assistant to the Associate Director for Intramural Programs, National Library of Medicine.*

prints, and other library materials pertinent to medicine; (2) organizes these materials by appropriate cataloging, indexing, and bibliographic listings; (3) publishes and disseminates catalogs, indexes, and bibliographies; (4) distributes materials through interlibrary loans, photographic, or other copying procedures; (5) provides reference and research assistance; and (6) encourages, promotes, and supports activities to further the progress of medicine and of public health by strengthening existing services and developing new ones.

Medical Library Assistance Act

The congressional mandate was strengthened recently when, on October 22, 1965, President Johnson signed the Medical Library Assistance Act, Public Law 89-291 of the 89th Congress. In signing the act, the President commented that the nation's medical libraries are a vital link between medical education, practice, and research, and that too little attention has been given to the problem of collecting and sharing scientific knowledge.

The Medical Library Assistance Act is an amendment to the legislation authorizing the establishment of the library. The act permits assistance to medical libraries for construction and renovation, for acquisition and for improvement of resources, for training of medical librarians and other information specialists, for preparation of publications, for research in medical library science, and for the development of regional medical libraries. The act also authorizes traineeships, fellowships, and special scientific projects by individuals or institutions.

Administration of the act on behalf of the library is done by the Library's Extramural Programs.

Serves as National Clearing House

The library today serves as the principal national focus of resources and programs for bettering communication in medicine and the health sciences, and is encouraging the development of the existing system of medical libraries into a national medical information network. On July 1, 1967, the library acquired the Public Health Service Audiovisual Facility in Atlanta, Georgia. This facility was renamed the National Medical Audiovisual Center and coordinates a national program in biomedical audiovisuals.

Access to the collection is facilitated through an interlibrary loan program. When libraries request loans through medical library channels, the National Library of Medicine lends books within the United States and, worldwide, provides single copies of articles from journals which the requesting libraries do not possess and which are not available locally. There is no charge for this service or for other services except special photography.

Extensive Historical Collection

The library collects materials comprehensively in some forty biomedical subjects categories and selectively in many related categories. The collection, in which there are over 19,000 serial titles, is increased annually by 95,000-100,000 items. It is estimated that the library now stores 360 million pages, of which 85 million are pre-1870, and that at least 10 million more are being acquired annually.

The History of Medicine Division alone has between 60,000 and 65,000 printed works bearing publication dates earlier than 1801. Included in the collection are: an Arabic manuscript of the year 1094 on gastrointestinal disease; a collection of palm-leaf manuscripts from Ceylon, in Singhalese; works of Hippocrates and Galen; and letters written by George Washington, Benjamin Rush, and Florence Nightingale. Holdings also include 535 incunabula; 33,000 sixteenth, seventeenth, and eighteenth century monographs; 1,600 seventeenth century theses and pamphlets; 2,000 early American medical works; and an estimated 60,000 prints and photographs.

Pioneer in Use of Computers

Efforts of conscientious, busy practitioners to achieve and to maintain awareness of the most recent medical discoveries and applications have often led to many and continuing frustrations. The increase in the volume of medical literature and in the number of users has not been parelleled by equivalent growth of medical libraries and of information storage and retrieval methods and facilities adequate to catalog, index, store, and retrieve literature for use of physicians, scientists, and others. Therefore, the library adopted computerization as a means of assisting, supplementing, and complementing traditional approaches to management of published biomedical literature and pioneered in the use of computers for storage and retrieval of bibliographic information.

In January 1964, a computer-based information storage and retrieval system called MEDLARS (Medical Literature Analysis and Retrieval System) became operational at the library.

MEDLARS joins the professional experience of trained literature analysts and searchers with the processing capabilities of a high-speed electronic computer. The literature analysts, using terms selected from a thesaurus of approximately 7,000 terms, *Medical Subject Headings* (Part II of the January issue of *Index Medicus*), characterize each article by assigning to it a number of subject headings or de-

scriptors. Indexed articles are entered into the computer and transferred to magnetic tapes for storage, and for rapid retrieval. Currently, MEDLARS contains over 550,000 citations to biomedical journal articles published since January 1964. About 55 per cent of these are in English.

MEDLARS has improved the quality of the library's monthly *Index Medicus* and has substantially reduced the time required for the production of other library bibliographies.

Index Medicus

Index Medicus, a comprehensive, monthly subject-author index, now incorporates 180,000 articles annually from nearly 2,300 of the world's biomedical journals. At the close of each calendar year, MEDLARS compiles *Cumulated Index Medicus*, a complete listing, with cross-references, of the citations which were printed in that year's issues of *Index Medicus*. (MEDLARS does not now include monographs, symposia, conferences, congresses, and proceedings not published in journals.)

The journals indexed in *Index Medicus* (approximately 2,300) are selected with the advice of an extramural committee whose decisions are made largely on the quality of the journal under consideration; however, care is taken to assure subject balance. Discussions of journals are based on prior knowledge of the journal and on inspection of the journal by committee representatives. In addition, the committee is assisted by advice from subject specialists. Comprising the present committee are physicians and scientists, medical editors, and medical librarians.

MEDLARS makes possible rapid machine searches of biomedical journal literature to obtain answers to reference questions that cannot be handled expeditiously by manual searches. Machine searches which provide citations to medical literature in specific areas of interest are called "demand bibliographies."

MEDLARS is responding to more than 400 highly specific computer search requests monthly. These requests are coming chiefly from physicians, teachers, and researchers in medical schools, hospitals, universities, and Federal research laboratories.

Prepares "Recurring Bibliographies"

In addition to demand bibliographies, the library collaborates with professional societies and other professional organizations in the preparation of "recurring bibliographies"—formally published, widely distributed bibliographies in specialized subject areas of broad interest. These recurring bibliographies are *Artificial Kidney Bibliography; Bibliography of Medical Education; Cerebrovascular Bibliography; Fibrinolysis, Thrombolysis, and Blood Clotting; Index of Rheumatology; Index to Dental Literature;* and *International Nursing Index.*

Although the library supplies the sponsoring organization with citations retrieved periodically from MEDLARS on film ready for offset printing, publishing and distributing the bibliography—on a nonprofit basis—are the responsibility of the sponsoring organization.

Publishes Monthly Bibliographies

At frequent intervals, generally monthly, the library selects from its demand bibliographies a few considered to be general interest. Announcements of the availability of these bibliographies, called *NLM Literature Searches,* appear in *Journal of the American Medical Association, Public Health Reports, Journal of the American Dental Association, NLM News,* and other publications, including state journals. There is no charge for these *Searches.* Clinicians, educators, and researchers interested in receiving notices on new *NLM Literature Searches* may write to the Office of Assistant to the Director, National Library of Medicine, 8600 Rockville Pike, Bethesda, Maryland 20014.

Affiliated Centers

To enhance effectiveness of MEDLARS, the library has provided its computer tapes and programs to university-affiliated centers which can make computer-generated demand bibliographies available locally or regionally to qualified practitioners, educators, and researchers. Decentralized MEDLARS stations are now in operation or will soon be in operation at Harvard University, the University of Alabama, the University of California at Los Angeles, the University of Colorado, and the University of Michigan. Others are being considered, and as regional libraries, authorized by the Medical Library Assistance Act, are identified, they, too, will be provided with a MEDLARS search cabability.

Two MEDLARS centers are in operation outside the United States: In the United Kingdom under a cooperative arrangement between the University of Newcastle-upon-Tyne and the National Lending Library for Science and Technology at Boston Spa, Yorkshire, demand bibliographies are provided by the Lending Library. In Sweden, literature references taken from MEDLARS tapes are being provided by the Karolinska Institutet in Stockholm.

How to Obtain Bibliographies

Physicians wishing to obtain demand bibliographies are encouraged to seek the advice of local

medical librarians on suitability of the inquiries and on the preparation of requests which will elicit the information sought. The use of *Medical Subject Headings, Guide to MEDLARS Services,* and an expression of specific interests will help avoid retrieval of irrelevant citations. Thus, a request specifying animal experiments will help to insure that citations on human studies will not appear in the bibliography; similarly, specifying a single age group will obviate retrieval on all age groups.

Citations may be arranged alphabetically by senior author, by journal title, by language, by subject headings, and by year of publication, and each citation can be printed with the descriptors assigned to it by its indexer. Although the computer can print bibliographies on 8½″ × 11″ paper or on 3″ × 5″ cards, usually the printout is provided on the less costly paper.

The elapsed time between receipt of a request and mailing of a bibliography is a function of the volume of searches requested. At present, elapsed time is about three weeks.

It is important to note that MEDLARS does not produce abstracts. It is also important to note that MEDLARS services are not provided for searches which can be conveniently and readily accomplished by the use of published indexes, handbooks, and other reference materials.

Demand Bibliography Requests From Georgia

During the period July 1966-June 1967, inclusive, the National Library of Medicine responded to 43 demand bibliography requests from biomedical personnel in the State of Georgia. Subjects ranged from Popliteal Aneurysm and Cerebellar Intention Tremor to Immunodiagnosis of Parasitic Diseases.

The distribution of the 43 requests was:

Emory University	4
Georgia State College	1
University of Georgia College of Medicine	3
Federal	29
Other (chiefly physicians)	6
Total:	43

Summary

The National Library of Medicine, now the world's largest biomedical library, was established by Congress to further the advancement of medical and medically related sciences by the collection, dissemination, and exchange of scientific and other information important to the progress of medicine and of public health. It has become an international as well as a national resource for publications and other items relevant to medical communication, and renders service on a world-wide basis.

In January 1964, a computer-oriented information storage and retrieval system called MEDLARS (Medical Literature Analysis and Retrieval System) became operational at the library. This system has improved the quality of *Index Medicus* and other library-associated publications and has substantially reduced the time required for preparation and publication of such publications.

The MEDLARS store of biomedical journal articles published since January 1964 now exceeds 550,000 and is growing at an annual rate of 180,000 articles, taken from nearly 2,300 journals. Requests for computer searches come chiefly from physicians, teachers, and scientists in medical schools, hospitals, universities, and Federal research laboratories.

During the period July 1966-June 1967, inclusive, the National Library of Medicine responded to 43 demand bibliography requests from biomedical personnel in Georgia.

FAMILY MEDICINE FOR MEDICAL STUDENTS

The Journal of the Medical Society of New Jersey

Medical education—like all education—comes in for a lot of brickbats these days. One of the current criticisms is that the medical student never gets to see a patient in his normal milieu, but only in the artificial environment of the hospital or clinic. This leads the student to isolate the illness from its social background. It makes him forget that patients have families. It leads to such absurdities as recommending that an arthritic and widowed scrub woman treat her arthritis by basking for the winter in Florida's sun and sand. And it leads away from "family practice" even though one of the avowed aims of the medical school is to train family doctors, rather than specialists.

It is heartening to see that at least one medical school is doing something about it. Vanderbilt University's School of Medicine has for some time operated a program in which medical students make regular visits to the homes of patients. They encourage the student to act as a family health advisor to a group of families. They learn the ministry of listening, the curious healing force that flows out of the relationship when the doctor will listen patiently and sympathetically. They do not see disease tied up into neat packages with all the "extraneous" or nonmedical aspects trimmed off. Instead they see disease as part of a total personality and see that total person as part of a family, of a neighborhood, of a community, which is as it should be.

Everyone talks about the "social" aspects of disease, about disease being a social phenomenon, as well as a biological one. Everyone talks about the importance of persuading young physicians to become true family doctors. But no one *does* anything about this. Well, almost no one. In Nashville, they *do* do something about it.

One hundred forty-seven patients constitute the nucleus for this case study.

Vaginitis in General Practice

JAMES H. KELLEY, M.D., *Atlanta*

VAGINITIS HAS BECOME an important medical problem of modern society for the female and for the physician treating her. This problem has been enhanced by ever increasing standards of feminine hygiene and the demand for comfort. No doubt also the spread of vaginal infection has been implemented by increased use of common facilities such as swimming pools, public toilets and the like.

On the other hand, knowledge of the various pathogens encountered has been substantially enlarged over the past few years; and the number of drug products now available to counter their action has greatly increased. Thus it appears that the function of the physician, beyond diagnosis, has almost resolved itself to selection of the optimum medication.

Considering the large number of products available for this purpose, many of which are designed to treat only a specific pathogen while few are designed to cover them all, the question has arisen as to whether optimum therapy would call for careful and sometimes expensive laboratory diagnoses followed by a treatment of the specific pathogen involved, or whether equal results might be achieved in most cases at a lower cost and with less time by using a medication designed to counter all well known vaginal pathogens at once as well as to correct the conditions associated therewith.

In view of the above, a test of one of the better known all-purpose vaginal medications in the office of a general practitioner appeared worthwhile, convenient and interesting, and same was unhurriedly completed over a period of several months.

Material

This purportedly all-purpose vaginal medication* was provided in two forms: the dry tablet-type insert and the vaginal cream, each delivering the same amount of medication per dose, the choice between the two being made at the convenience or preference of the patient. Each insert, and each 4 gms. of the cream, contain Diiodohydroxyquinoline, 100 mg.; Sulfadiazine, 500 mg.; and Diethylstilbestrol, 0.1 mg., in a base containing sodium lauryl sulfate, tartaric acid, boric acid, dextrose, and lactose, in addition to preservatives and fillers. The patient was instructed to place the insert, or the 4 gms. of cream, by use of the applicator in each package, high into the posterior fornix of the vagina morning and evening for a period of 12 days, the time required to use the contents of one stock package. Some cases required additional amounts of the medication for use over a longer period as indicated hereinafter.

Method

One hundred forty-seven female office patients complaining of vaginitis were used in this study, each being selected in chronological order. Of this total, 81 were diagnosed by both observation and laboratory report, 53 by laboratory report only, and 13 by observation only. Forty-three cases were diagnosed as Monilia, 25 by laboratory and observation, 16 by laboratory, and two by observation only. Seventy-eight cases were diagnosed as trichomonas, 46 by laboratory and observation, 21 by laboratory, and 11 by observation only. Twenty-six cases were diagnosed as mixed vaginitis, 10 by laboratory and observation, and 16 by laboratory only. Accessory medication, metronidazole, was used in 23 cases of trichomonas, three cases of monilia and two cases of mixed vaginitis.

Each patient was requested to report the number of days from start of medication until she became symptom-free. Thus the first criterion for evaluation of results is the number of days required for the patient to become asymptomatic.

* *Gynben, Inserts and Cream, Bentex Pharmaceutical Co., Houston, Texas.*

The second criterion was the number of days required for the patient to become pathogen-free. This, of course, was more difficult to determine. Most such determinations were made by discontinuing the medication at a point where the physician considered the patient cured (this decision being made in a few cases by the patient) and the decision considered to have been correct if the infection did not recur within a month or longer. Obviously a number of the patients were actually pathogen-free before the time reported, hence the average time so reported is assumed to be more than actual.

Results

The findings are reported in Table I. Of the 43 cases of monilia, two did not return. One patient did not continue the medication, claiming that the inserts did not dissolve. The average number of days reported by the other 41 cases to become asymptomatic was 3.3. Only 33 of these 43 patients returned or were available for pathogen-free determination. The average time reported for these 33 was 10.9 days. It is logical to assume that good results were encountered in most of the other ten patients, as is evidenced by their not returning.

Of the 78 patients diagnosed as trichomonas, all reported the time to become symptom-free, which averaged 3.1 days. Sixty-nine of the 78 patients were available for the pathogen-free determination and the average time reported here was 14.5 days.

Twenty-five of the 26 patients with mixed vaginitis were available to determine time required to become asymptomatic, and the average was 3.2 days. Twenty-four of the 26 were also available for the pathogen-free determination, and the average time here was 11.5 days.

As an overall average, 145 of 147 patients averaged 3.2 days to become asymptomatic. One hundred twenty-six of 147 patients averaged 12.9 days to become pathogen-free.

In the above tabulations, it must also be considered that two of the cases of mixed vaginitis also received accessory medication (metronidazole) as did 23 of the cases of trichomonas. Three cases of monilia also received this medication, although same is not claimed to be effective therein.

Discussion

Other similar clinical studies on the use of Gynben[1-5] have indicated that this multiple-purpose therapy has achieved worthwhile results in monilia, trichomonas, haemophilus vaginitis, atrophic vaginitis, and mixed infections. This study substantiates in general the previous findings with respect to monilia, trichomonas, and mixed vaginitis.

The use of a multiple-purpose vaginal preparation, however, should not preclude a proper clinical examination of the area to determine other contributory pathological conditions, if any. However, a number of advantages were encountered in this type of medication. First, many patients reported themselves symptom-free before the laboratory reports on their cases were returned. Second, such an all-purpose medication appears imperative, of course, for mixed vaginal infection. Third, the cost of such medication is usually considerably less than the cost of the laboratory determination plus the specific medication.

No side effects were reported from the use of Gynben by any of the patients involved in the study, nor were any observed.

As previously concluded by other clinicians, Gynben is considered a convenient all-purpose medication affording consistent significant results in combating vaginal pathogens. It has proven safe, convenient, and effective.

Summary

1. One hundred forty-seven female office patients complaining of vaginitis were treated and studied by a general practitioner.

2. These patients were classified into three groups: those infected with monilia, those with trichomonas, and those with mixed infections.

3. The patients were given the usual dose of the medication which consisted of vaginal application of the material twice daily for about twelve days.

4. As an overall average, the patients became

TABLE I

	To Become Symptom-Free		To Become Pathogen-Free	
	No. Reporting	Avg. Days	No. Reporting	Avg. Days
Monilia	41 (of 43)	3.3	33 (of 43)	10.9
Trichomonas	78 (of 78)	3.1	69 (of .78)	14.5
Mixed	25 (of 26)	3.2	24 (of 26)	11.5
Total	144 (of 147)	3.2	126 (of 147)	12.9

asymptomatic in 3.2 days. The average time required to become pathogen-free was 12.9 days.

5. None of the patients reported any side effects from the medication, nor were any observed.

6. Three patients were not available for the asymptomatic determination and hence were not considered. The same is true of 21 patients with respect to the pathogen-free determination.

7. Gynben is considered in this study to be a convenient all-purpose medication affording consistent significant results in combating monilia, trichomonas, and mixed vaginitis.

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SURVEY STUDIES FACILITIES FOR EMERGENCY CARE

Within the next twelve months, a survey of existing facilities for emergency medical care will be completed. Why is there a need for such a study? Many private ambulance services no longer participate in transportation of the injured. The many fine funeral services in Georgia which have provided such community goodwill service have suffered tremendous financial indebtedness by this service. Less than 25 per cent of such services is reimbursed.

Rural Facilities Need Improvement

Seventy per cent of accidents occur in rural areas where fatalities are four times greater than in urban injuries. Existing facilities do not, as a rule, provide trained ambulance attendants knowledgeable in first aid and rescue which is necessary to reduce the incidence of death or permanent crippling injury. Communication for directional and management care of the injured between site of injury and emergency facility is nonexistent in Georgia.

Rural-urban cooperation through planning councils is only now beginning to appear in Georgia. Habersham County has established the first such united effort. Adult driving education courses, first aid and rescue instruction, and improved emergency care are important aspects of this progressive program.

Apathy Is Major Offender

Unfortunately, our "accidental" death toll will continue to increase in Georgia for years. The reason is two fold: apathy and conflict of interests. Only when each driver is equipped with first aid knowledge and is a skilled and physically fit driver in a safe vehicle on a safe highway will the carnage disappear.

There is no compromise—Do you know First Aid? What are you doing to save your life and the lives of others?

AHA TO SET GUIDELINES FOR HEART TRANSPLANTS

Human heart transplantation problems will be thoroughly investigated by the recently established American Heart Association Committee on Ethics. Detailed guidelines will be developed for the medical profession and the public. Approval of the committee's study recommendation was announced in early May by Dr. Lewis E. January, Chairman of AHA's Committee for Medical and Community Program.

The committee is composed of leading authorities in medicine, law, religion, education and communication. Chairman of the Ethics Committee is Dr. Eugene A. Stead, Florence McAlister Professor of Medicine, Duke University, Durham, N.C.

Areas to be investigated include the following: establishment of criteria for death and the rights of the donor; formulation of criteria for selection of a recipient; development of technical guidelines for institutions and surgical teams planning transplantations; identification of potential donors and establishment of organ registries; development of legal safeguards to protect donor, recipient and physician; development and treatment costs of artificial heart, heart transplant programs, and recommendations for future national financial commitments, and; guidelines for continuous public education. Study group reports will be reviewed by the committee in the fall.

A statement on heart transplantation was recently issued by the Board of Medicine of the National Academy of Sciences, and AHA's Ethics Committee expressed approval of three basic criteria contained therein: Cardiac transplantation, as a therapeutic trial, requires an advance overall plan of study; transplantation should be permitted only when the surgical team can meet the most exacting standards of technical and scientific capability; and meticulous scientific standards must be set for selection of donors and recipients.

While a few dermatologic disease states respond to specific therapeutic replacement of deficient vitamins, there are many other disorders of the skin which respond to large doses of vitamins utilized as pharmacologic agents.

Vitamins in Dermatology

LEONARD FISHMAN, M.D., *and* MARTIN GOLDSTEIN, M.D., *Atlanta*

In the early 1900's when Funk isolated thiamine and demonstrated its effect in the treatment of beriberi, vitamins made their scientific entry into the field of medicine and nutrition. Since that beginning, many vitamins have been described, their structure and functions elucidated, and now are useful in many medical disciplines.

This report is intended to focus attention on those vitamins which have found some usefulness in the maintenance of normal skin. This discussion will include the changes of hyper and hypo vitaminoses and the reflection of these changes in the structure and function of the skin, as well as the treatment of various dermatologic disorders of unknown etiology with vitamins.

No attempt will be made to discuss in detail the specific biochemistry of these metabolically active substances, their formation and excretion, or the minimal daily requirements. Let us say only that they take part in essential metabolic reactions and in general must be supplied by the diet and/or the action of intestinal bacteria, as they are not synthesized by man.

Vitamin A

Vitamin A, a lipid soluble vitamin, has probably been used more often and provoked more controversy than any of the other vitamins used in dermatology, yet, there is no unanimity of opinion as to its mode of action or even to its effectiveness.

"Bitot's Spots"

Some years ago workers in China[11] noted a syndrome of xerophthalmia, keratomalacia, "Bitot's Spots," and dry skin with follicular keratotic plugs among groups of Chinese peasants and soldiers on bare subsistence diets. Diets high in vitamin A content reversed these findings. This syndrome is now known as phrynoderma and is due to depletion of body stores of vitamin A.

Studies in China by Frazier, et al.[10] revealed the xerosis of phrynoderma to precede follicular plugging and that follicular plugging was associated with sexual maturity—the younger children showing only dry scaly skin. Malformation of the follicle and sebaceous gland atrophy follow the follicular plugging. During the preadolescent years, ocular abnormalities are most conspicuous in vitamin A deficiency and include conjunctival pigmentation. Bitot's spots are the slate-gray color associated with the plugged follicles.

Because of the resemblance of the skin changes in a number of dermatologic disorders to the changes seen in hypovitaminosis A and the apparent effect of vitamin A on keratin metabolism, vitamin A has been used therapeutically in many skin disorders. (See table I)

Studies of vitamin A and carotene (provitamin A) levels in the sera of patients with the more common disorders are generally normal. The less common syndromes have been found by some workers[17] to have low normal serum vitamin A. This does not mean that a lack of vitamin A is etiologically responsible for the disease state since in many instances after administration of vitamin A and normal serum levels have been established there is no apparent change in the cutaneous disorder.

Effect on Epidermal Cellular Metabolism

To explain this apparent paradox it becomes necessary to investigate further the effect of vitamin

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A on epidermal cellular metabolism. Pinkus and Hunter[21, 14] studied the keratinizing effects of systemic vitamin A given orally in high dosage and found a decrease in the number of horny cells. They also found a decreased mitotic response after stripping the stratum corneum from intact skin (scotch tape method). They noted an increase in the per cent of basal and prickle cells in relation to keratinized cells and surmised that vitamin A has an effect which delays epidermal maturation.

Untreated animals deficient in vitamin A have a decreased mitotic index. These animals also have a keratinizing mucosal metaplasia[26] which may be attributed to the lack of vitamin A stimulus on the basal epithelial cell to produce mucus. Vitamin A deficiency is associated with an increase in connective tissue Mucopolysaccharide.[12]

Sherman[26] pointed out that physiologic amounts of vitamin A given to deficient animals increase the mitotic index while massive (toxic) doses decrease mitotic activity in the deficient and in the normal animal. This is in agreement with the work by Pinkus and Hunter.

Flesch[8, 9] demonstrated inhibition of keratinization by vitamin A and felt this was probably due to interference of skin sulfhydryl metabolism.

Another interesting effect of vitamin A in excess of normal requirements is an unstabilizing effect on lysosomes. Under certain conditions which are dose and temperature dependent, Vitamin A may cause the release of hydrolytic enzymes.[5]

Absorption of Vitamin A

Important to any discussion of vitamin A and the effects it may have on cellular metabolism is an understanding of vitamin A absorption and storage. It may be absorbed as a fat soluble or as an aqueous dispersion in the form of a free alcohol or ester. When taken orally in excessive amounts, much of the vitamin A may be recovered unabsorbed in the feces.

Vitamin A is also absorbed when applied topically to skin and mucous membranes. Sobel[29] demonstrated skin changes at the site of application and elevation of plasma and liver vitamin A in rats. The topical route is ineffective in altering distant sites and is also not likely to be associated with toxic manifestations. Flesch[8] was unable to demonstrate significant absorption of topical vitamin A in man, but others [3, 20, 28] have shown epithelial changes following topical treatment. Local application is often more effective in treatment of limited areas and essentially removes the problems of toxicity associated with systemic therapy.

Carotene is converted to vitamin A in the intestinal wall,[12] and in normal skin carotene is taken up by sebaceous glands and converted to vitamin A and delivered directly onto the skin as shown by Greenberg and Cornbleet[13] with fluorescence microscopy. In pityriasis rubra pilaris and ichthyosis they failed to demonstrate carotene take-up and conversion to vitamin A by sebaceous glands. They postulated this may occur because of defective or absent sebaceous glands or follicular plugging.

TABLE I
USE OF VITAMIN A

Disease	Treatment Form
Ichthyosis	Oral and 0.1% Vitamin A Acid Ointment
Pityriasis Rubra Pilaris	Oral and Topical
Keratosis Pilaris	Oral
Acne (papular-comedone)	Oral
Keratosis Follicularis (Darier's)	Oral
Leukoplakia	Troches 300,000-900,000 units per day dissolved against lesions (recurrence frequent)
Seborrheic and Actinic Keratosis	Oral—(many months)
Warts	Intralesional Vitamin A Palmitate 0.1-0.4 cc (50,000 units per cc)
Keratosis Palmaris et Plantaris	Oral and Topical
Atopic Dermatitis	Oral and Topical
Lichen Planopilaris	Oral
Brittle Nails	Oral

Storage in the Liver

After the vitamin A has been absorbed, it is taken for the most part to the liver for storage. Blood levels after a large dose reflect hepatic storage, since the most recently absorbed vitamin A displaces previous liver stores into the circulating blood. Therefore, if there is an increase in serum vitamin A, it indicates adequate hepatic storage. Ruch, et al. found liver stores depleted of vitamin A in darier's and congenital dyskeratosis.[22]

In vitamin A deficiency, serum levels are maintained by release from the liver until depleted. The symptoms of vitamin A deficiency become apparent when the blood level drops below 40 units/100 ml. In hepatitis and other primary liver disorders, the release mechanism may not function normally and blood levels of vitamin A may drop, despite adequate hepatic stores.

Pharmacologic Agent in High Doses

From the above discussion it becomes apparent that although vitamin A plays a definite role in epithelial metabolism and especially keratin formation, and in deficiency states a striking and reproducible syndrome occurs, its effect in the various dermatological disorders of keratin metabolism is not a simple deficiency replacement. It would appear

that vitamin A becomes a pharmacologic agent in high dosage. These high doses may be necessary in certain disease states that have altered end-organ response to normal levels or, as Leitner and Moore[17] postulate, the action of massive doses may be the result of spill-over of vitamin A from blood and stores into tissues not accustomed to these levels of the vitamin, thereby exerting a pharmacologic effect.

Risks of Vitamin A Therapy

Vitamin A therapy is not without risk. Although it takes many months of excessive intake to develop symptoms,[3, 12, 30] hypervitaminosis A may be produced, and is often an insidious process presenting considerable diagnostic difficulties. Some of the more common and important findings include: fatigue, bone and joint tenderness, hair loss, increased pigmentation, vague abdominal pains, exophthalmos (does not regress after discontinuing vitamin A), premature closure of epiphyses (children), hyperostoses, dry lips, leukopenia and many of the same changes associated with hypovitaminosis A or phrynoderma.

Vitamin B_{12}

Vitamin B_{12} (cyanocobalamin) is formed in nature by microorganisms. Man is supplied vitamin B_{12} by ingestion of animal tissue where it is present as various metabolically active coenzymes.

Vitamin B_{12} is utilized in every known metabolic system in man.[12] It is necessary for normal growth, nutrition, hematopoiesis, epithelia and for the maintenance of myelin throughout the nervous system. It is needed for cell replication in proportion to the rate of turn-over.

Although cyanocobalamin is specific only in the treatment of vitamin B_{12} deficiency, it has been felt useful in several disorders of the skin. Many clinicians have used vitamin B_{12} in psoriasis, seborrheic dermatitis, leukoplakia, and zoster.

As stated in the discussion of vitamin A, the favorable results in treatment of these dermatologic disorders with dosages far in excess of total body needs, may be due to a pharmacologic action of cyanocobalamin on epithelium, especially since it is known to have direct effects on sulfhydryl and disulfide metabolism.

Toxic effects from the clinical use of crystalline cyanocobalamin have not been reported. However cases of urticaria have been reported from the phenylcarbinol preservative used in solution of vitamin B_{12}.

Nicotinic Acid

Nicotinic acid is the primary deficiency in pellagra, but in pellagra, as in the other deficiency syndromes, there are usually associated deficiencies of other vitamins.

The most interesting cutaneous change in nicotinic acid deficiency is the photodermatitis so characteristic of pellagra. A similar eruption may be seen in the Carcinoid Syndrome due to a shift in tryptophan metabolism, and in Hartnup's Disease due to nicotinic acid deficiency.

Other manifestations of nicotinic acid deficiency include stomatitis, glossitis, diarrhea, insomnia, delusions, dementia, peripheral neuropathy, macrocytic anemia, and porphyrinuria.[12]

Nicotinic acid may be given with impunity because of an enormous therapeutic index. Some effects of nicotinic acid therapy in non-deficient situations include an increase in sebaceous gland secretion, vasodilatation and associated itching and burning, lowering of the blood cholesterol, and when given parenterally, nicotinic acid will produce fibrinolysis (short acting). Abnormal glucose tolerance curves have been associated with large doses of nicotinic acid, as have an impairment in liver function studies. Nicotinic

TABLE II
USE OF OTHER VITAMINS

Vitamin	Disease	Treatment Form
Vitamin B_{12}	Seborrheic Dermatitis, Psoriasis, Zoster, Leukoplakia	Parenteral
Vitamin C and Flavonoids	Scurvy Purpura, Onycholysis, Acrocyanosis, Cholasma	Oral
Nicotinic Acid	Pellagra, Vascular Insufficiency, Chilblains, Carcinoid Syndrome, Xerosis, Hartnup's Disease, Photodermatitis (non-specific)	Parenteral and Oral
Pyridoxine	Herpes Gestationis, Seborrheic Dermatitis in conjunction with Isoniazid Therapy	Oral and 1% Pyridoxine Cream
Vitamin E (Tocopherol)	Epidermolysis Bullosa, Lupus Erythematosus, Granuloma Annulare, Cutaneous Ulcers (non-specific), Dupuytrens Contracture	Oral and Topical Cream
Thiamine	Zoster, Pellagra	Oral and Parenteral
Riboflavin	Pellagra	Oral
Vitamin D	Sarcoidosis, Acute Exudative Eczema	Oral
Paraamino Benzoic Acid	Sun screen	Topical

acid and nicotinamide may be used interchangeably —the amide does not produce vasodilatation, fibrinolysis or decreased cholesterol.

Nicotinic acid is used in dermatology in pellagra, in the cutaneous manifestations of vascular insufficiency, chilblains, Carcinoid Syndrome, xerosis, Hartnup's Disease and non-specifically in suspected photodermatitis of unknown etiology.

Pyridoxine (Vitamin B_6)

Pyridoxine (vitamin B_6) deficiency in man results in a seborrhea-like dermatosis, glossitis, stomatitis, and peripheral neuritis. There may also be photosensitivity and pellagra-like changes due to the necessity for pyridoxal-5-phosphate in the conversion of tryptophan to nicotinic acid.[34]

Pyridoxine has been used in the treatment of herpes gestationis,[4] for prophylaxis against the peripheral neuropathy associated with isoniazid therapy, in conjunction with nicotinic acid in pellagra, and for seborrheic dermatitis. (A topical preparation of 1 per cent pyridoxine cream has been used in seborrheic dermatitis.)[34]

Vitamin E (Tocopherol)

Vitamin E (Tocopherol) is a very controversial substance and its value and need by man is even less well defined than the other vitamins. There is very little concrete evidence of any function for vitamin E but it has been used in epidermolysis Bullosa[35] by systemic and topical routes, and in cutaneous ulcers of any etiology (non-specific). Other uses in dermatology include lupus erythematosus, granuloma annulare, and Dupuytrens Contracture.

Thiamine, Vitamin B_1

Thiamine, vitamin B_1 is essential in the intermediary metabolism of carbohydrate. Deficiency results in the cardiovascular and neurologic manifestations of beriberi. Thiamine is found in all tissues, but storage is mostly in liver, brain, kidney and heart.

The use of Thiamine is indicated in beriberi and alcoholic neuritis; however, it has been used in dermatology in zoster and in pellagra.[18] The toxic dose is extremely high, but may result in respiratory failure. There has also been allergic eczematous sensitivity reported from thiamine with cross reactivity to cocarboxylase.[12]

Riboflavin (B_2)

Riboflavin (B_2) deficiency in man is associated with corneal vascularization and is often associated with pellagra. The most commonly associated mucocutaneous manifestations are glossitis and angular stomatitis. There is also a seborrheic-like scaling of the nose, naso-labial folds, and ears.

Vitamin B_2 is a useful adjunct in the treatment of pellagra but angular stomatitis and seborrhea seldom if ever respond to riboflavin therapy.

Vitamin D

Vitamin D is primarily concerned with calcium metabolism and will increase intestinal absorption of calcium. It also affects the mobilization of bone salts to the blood stream. In deficiency states there is adequate absorption of calcium and phosphorus, and in the growing individual the result is rickets, while in the adult it is osteomalacia. If Vitamin D is in excess, osteoporosis and calcium deposits in various organs occur.

In sarcoidosis the elevated serum calcium levels have been attributed to Vitamin D, yet Vitamin D has been used in the treatment of this disorder. Vitamin D has also been used in the treatment of acute exudative eczema.

Vitamin C

Vitamin C is essential for the formation and maintenance of intercellular ground substance and collagen. In deficiency states, the collagen bundles disappear, and the ground substance depolymerizes and takes on a thin and watery appearance. Recent investigators[27] have studied the effect of ascorbic acid on human fibroblasts in tissue culture. It was shown that Vitamin C acts directly on fibroblasts to promote collagen synthesis. This is the explanation for impaired wound healing in Vitamin C deficiency. Vitamin C also functions in the metabolism of tyrosine, thereby exerting an influence in pigment formation.

Vitamin C is, of course, specific in the treatment of scurvy. It has also been used in the treatment of purpura—particularly the benign pigmented purpuras, onycholysis, acrocyanosis, chloasma and in the past, as an adjunct in the treatment of cutaneous tuberculosis. No toxicity has been associated with Vitamin C therapy in man.

Flavonoids

An interesting group of substances closely allied to Vitamin C, which may be an aide in the treatment of disease states characterized by capillary bleeding are the Flavonoids or Vitamin P.

The concept of Vitamin P developed from observations by Szent-Gyorgyi[31] that crude preparations of ascorbic acid obtained from natural sources were more effective in alleviating the capillary lesions and prolonging the life of scorbutic animals than was the purified vitamin. Since the active material was concerned with capillary permeability, and believed to be distinct from vitamin C, it was named vitamin P (P for permeability).

The exact nature of the flavonoids has not been established. However three chemically related compounds that have an action characteristic of vitamin P have been described, and they are rutin, quercetin and hesperidin.

The flavonoids have a direct constrictor action on the capillary bed and decrease the permeability and the fragility of the vessels. Because of this action they have been used with some success in conjunction with Vitamin C in the treatment of purpuras associated with increased capillary fragility. (The indications are the same as those given for Vitamin C.)

No toxicity has been reported for this group. either alone or in combination with Vitamin C.

Folic Acid

Folic acid deficiency commonly results in a megaloblastic anemia, but may also be associated with glossitis. The metabolism of folic acid is currently important to dermatology because of the use of Folic acid antagonists in therapy of certain cutaneous disorders.

Para Amino Benzoic Acid

Paraamino benzoic acid is mentioned because of its use as a sun screen. It is important also because of the structure it has in common with a number of photosensitizers.

Summary

In summary, there are few dermatologic disease states for which vitamins serve a specific therapeutic replacement. However, the use of vitamins in large doses to act as pharmacologic agents has been beneficial in the therapy of many disorders of the skin.

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EMORY STUDENT IS LEADER IN SAMA

Christian N. Ramsey, Jr., of Emory University School of Medicine, was elected vice-president of the Student American Medical Association. This organization has a membership of 60,000, and represents 85 medical schools in the United States. The announcement was made after the 18th annual meeting of SAMA held in Detroit.

Favorable results are reported in this study of thirty-four patients.

The Use of Thioridazine in the Treatment Of Acute Brain Syndrome Due to Alcohol

JULIUS EHIK, M.D., *Atlanta*

ALCOHOLISM RANKS AFTER CANCER, mental illness and heart disease as the fourth leading health problem in the United States.[1] Yet, the medical community gives little more than lip service to the disease concept of alcoholism. In New York City, for example, only three general hospitals accept alcoholics without restriction,[2] this despite reports in the literature which state that 90 per cent of alcoholics can be treated in such hospitals. Even psychiatrists betray conscious and unconscious resentment against alcoholics; almost half do not treat alcoholics at all.[3] This leaves the private mental hospital as the major resource available for the voluntary treatment of alcoholics, but many of these are overburdened because large numbers of patients vie for limited bed space.

At times, as many as one third of the patients in this 35-bed psychiatric hospital* are alcoholics. Most of them are severely intoxicated on admission and are hospitalized for "drying out," i.e., treatment of the acute brain syndrome caused by alcohol intoxication. An evaluation of the efficacy of one of our treatment methods is reported here.

Material and Method

Thirty-eight alcoholics admitted during a three-month period were studied. Two patients were hospitalized three times each, leaving a total of 34 individuals, 26 males and 8 females, aged 25 to 76 years, median 44.5 years. All but three patients were between the ages of 33 and 57 years. Twenty-one patients disclaimed previous hospitalization for alcoholism, the others had been hospitalized previously from one to "many" times.

Patients were divided into two groups according to the severity of symptoms on admission. The characteristics of the two groups are shown in Table I. Though the degree of intoxication was similar for both groups, the presenting withdrawal symptoms were much more severe in patients in Group I.

For controlling the psychomotor agitation, anxiety, tremulousness and insomnia which plague patients during the withdrawal phase, we employed thioridazine in a liquid form (Mellaril Concentrate). Dosage was adjusted according to the severity of symptoms. (See Table I.)

In addition to thioridazine, patients received diphenylhydantoin, magnesium sulfate, vitamin B-complex, and if indicated, intravenous fluids. Patients in delirium tremens received supplemental doses of sedatives for sleep, if necessary.

A few of the most seriously ill patients received gradually decreasing doses of alcohol during the first 48 hours, starting with one ounce every four hours. This concomitant administration of thioridazine and alcohol did not produce over-sedation.

Results

Group I: Eleven of the 21 patients showed good results with thioridazine. In these patients, the alcohol withdrawal syndrome was resolved rapidly, without the development of delirium tremens. They required few or no supplemental sedatives.

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Eight patients were rated as fair, i.e., they experienced some symptomatic relief, but required additional sedation to prevent or alleviate delirium tremens. Two patients had to be changed to parenteral phenothiazines and were rated as poor.

Five patients were not rated. One died shortly after admission and before thioridazine was administered; the others left the hospital, either by administrative transfer or against medical advice, before adequate ratings could be made.

Group II: The results with thioridazine were rated as excellent in one patient and as good in the other seven. In this group, thioridazine effectively alleviated withdrawal symptoms. Only occasionally did a patient require a supplemental sedative for sleep.

Side effects were mild and not troublesome. Dry mouth was observed in practically all patients, but it could not be determined whether this was produced by thioridazine or by the normal dehydration seen during withdrawal. Eight patients complained of being drowsy or groggy and one developed slurred speech during treatment. All side effects cleared up as treatment was continued.

Discussion

The treatment of the alcohol withdrawal syndrome varies from institution to institution, tacit evidence that there is no "specific" for this indication. The method reported here is one which had been successfully used in this hospital for some time, an impression which was confirmed in the present study. More than half of the most severely ill patients and all of the less ill ones obtained good results as manifested by the alleviation of symptoms such as anxiety, agitation, hostility, tremors, insomnia and hallucinations. This produced additional benefits by easing the total management of patients during the withdrawal phase.

Hayman[4] has found thioridazine to be very valuable in treating acute alcohol withdrawal. It has helped both in excited and apathetic withdrawn patients, and has been at least as effective as any of the other phenothiazines. An important advantage of this drug is that large numbers of alcoholics with cirrhosis have been treated with thioridazine without detrimental effects.[5] Moreover, thioridazine is nonaddicting; therefore, its use eliminates the undesirable practice of substituting a habit-forming sedative or minor tranquilizer for the habit-forming drug, alcohol.

TABLE I
Characteristics of Treatment Groups

	Group I	Group II
Number of patients	26	8
Median age	45 years	41.5 years
Previously hospitalized	42 per cent	25 per cent
Withdrawal symptoms	Extremely severe	Moderate to severe
Abnormal drinking patterns	Long-standing	Recent
Impending DT's on admission	Most patients	Few patients
Thioridazine dosage		
Stat.	200 mg.	100 mg.
Maintenance	50-200 mg. q.i.d.	50-100 mg. q.i.d.
Most frequent	200 mg. q.i.d.	100 mg. q.i.d.
Supplemental sedation	Needed frequently	Needed rarely
Duration of withdrawal symptoms	5-10 days	3-5 days

Emotional Support Effective

The effectiveness of our treatment program was undoubtedly enhanced by the capable nursing staff who provided emotional support to patients during the withdrawal period. They were also able to prevent complications by remaining alert for changes in vital signs and by forestalling injuries from falls and other accidents. They found the liquid form of thioridazine effective as well as easy to dispense and administer. It eliminated "cheeking" or hoarding of medication, saved nursing time by reducing the need for injections and permitted dosage adjustment without the knowledge of the patient.

Summary

This study has demonstrated the usefulness of thioridazine in the treatment of the acute brain syndrome due to alcohol. Its effect was especially apparent in the relief of psychomotor agitation, anxiety, and insomnia occurring during the period of alcohol withdrawal. No troublesome side effects were encountered. The liquid form (Concentrate) proved to be especially advantageous in this patient population.

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3. Hayman, M.: Current attitudes to alcoholism of psychiatrists in California; *Amer. J. Psychiat.* 112:117 (December) 1955.

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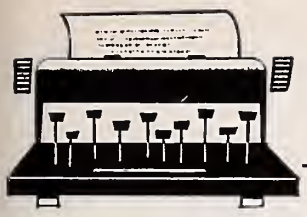
1325 West Peachtree St.



EDITORIALS

New Membership Benefit: An Umbrella

A MAILING WILL SOON BE SENT to every member of the Medical Association of Georgia advising him of MAG's endorsement of a new insurance plan for catastrophic liability coverage, commonly known as umbrella coverage. This mailing will come from the First National Investors, Inc., exclusive agents for the new plan which is underwritten by the Crum and Forster group of insurance companies. The Insurance and Economics Committee of MAG has spent considerable time and effort investigating all group catastrophic liability plans available in the insurance market and securing this new group plan for the membership; and none too soon as indicated by the following quote from *Medical Economics,* May 27, 1968:

> "MANDATORY $1,000,000 MALPRACTICE COVERAGE COMING? That's the outlook for high-risk specialties if other carriers follow the lead of the company that writes group coverage for most doctors in 23 California counties. American Mutual Liability now demands that anesthesiologists who buy basic $100,000/$300,000 policies also have umbrella coverage up to $1,000,000."

Some of the most frequently asked questions and answers regarding our new plan are as follows:

1) Is participation mandatory? No, it may be purchased voluntarily.

2) Will premiums remain the same? Rates are guaranteed not to increase for three years and are subject to annual review by the MAG Insurance and Economics Committee.

3) Will there be one master MAG policy? No, each insured receives his own contract; MAG merely supervises the premium.

4) Will this plan be "experience rated" like our basic coverage obtained through the St. Paul Insurance Company? Yes, premiums are based on four different specialty groupings with premiums adjusted to the amount of underlying professional liability being carried, and the annual premium review will be based on our own Georgia experience.

5) Do I really save money under the MAG plan for members only? Yes, this initial offering will be 30 per cent less than "standard" rates for the same coverage.

Many other aspects of this new plan will be explained in the mailing, and perhaps the most appealing feature of all will be: What happens to those who already have umbrella coverage through the Crum and Forster Plan? The agency will pick up these plans and re-write them, reducing the premiums an average of 30 per cent.

Treatment of Parkinsonism With L-Dopa

Dr. George Cotzias and associates of Brookhaven Laboratories showed movies of a major breakthrough in all types of Parkinson's Disease at the meeting of the Association of American Physicians in Atlantic City May 7, 1968.

His decision to try L-Dopa in Parkinsonism was not fortuitous. The substantia nigra is known to synthesize the amines which act on the corpus striatum, where the defect in Parkinson's Disease is located. He found the substantia nigra to be depigmented in cases of Parkinsonism at autopsy and surmised that there might be a deficiency of dopamine. Dopa both D- and L- are precursors of dopamine but D-Dopa and DL-Dopa were both toxic to animals, whereas L-Dopa was well tolerated. He gave four to eight grams of L-dopa to 26 patients with all varieties of Parkinsonism for 4 to 22 months.

In mild cases the effect was dramatic with complete disappearance of akinesia, rigidity and tremor—in that order. Symptoms reappeared in reverse order when the drug was discontinued. Movies showed the effects to be spectacular. Even in the worst case of a 76-year-old woman who had been unable to feed herself, improvement was so striking that she could carry food to her mouth with ordinary eating utensils with ease. Patients in wheelchairs who required aid to rise and maintain the upright position were actually running around outdoors, playing and catching a ball!

Dr. Cotzias noted that some patients who were almost normal in the mornings relapsed after lunch. He found this to be associated with high protein meals and that it could be prevented by substituting a low protein meal. Of the amino-acids, he found that phenylalanine caused the same type of relapse and that it caused an exacerbation of Parkinsonism in patients untreated with L-Dopa. Administration of L-Dopa was found to increase renal excretion of phenylalanine. Dr. Cotzias believes that phenylalanine and Dopa or Dopamine compete with each other in a common transport mechanism in nerve cells.

Effects of the drug have been undiminished for as long as 22 months. Ten patients on long-term therapy have developed some involuntary movements which are not disabling. Three patients became moderately hypertensive.

This investigation opens up the whole field of neurochemistry, and, already, success has been reported in marked relief of muscular rigidity in manganese poisoning. There is good reason to believe that other types of tremor, muscular rigidity and dyskinsia may respond to L-Dopa.

Arthur J. Merrill, M.D.

GEORGIA HIGHWAY SLAUGHTER

Yearly Totals

1968 to date	654 Killed
1967	1,618 Killed
1966	1,605 Killed
1965	1,354 Killed
1964	1,314 Killed
1963	1,278 Killed
1962	1,106 Killed
1961	1,017 Killed

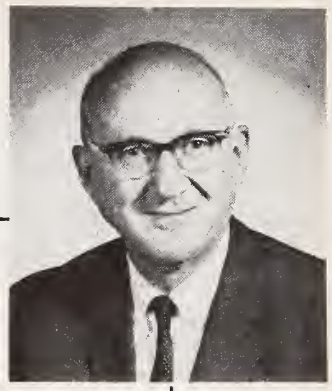
Through May, 1968
654 KILLED

Same Period 1967
634 KILLED

May, 1968
133 KILLED

Economic Loss

1968 to date	$124,260,000
1967	307,420,000
1966	288,900,000
1965	243,720,000
1964	236,520,000
1963	230,040,000
1962	199,080,000
1961	162,720,000



WOULD YOU RATHER COMMUNICATE OR PROCRASTINATE?

WHETHER YOU REALIZE IT or not your MAG is big business. It is your business and it is your affair. The future life of organized medicine depends on proper and adequate communication. Does the average doctor have the true relationship and rapport with his colleagues and contemporaries? The whole world is tied so tightly into a communication system that it is impossible for anyone to become released; therefore, the better we communicate the stronger we will be. Let us not put off exerting every effort to improve our communications. It is most important in these days to put aside personal jealousies and have a meeting of the minds with regard to differences of opinion. The socialistic trend and the welfare state are upon us like a huge octopus with its tentacles encircling the globe. It seems to me that we are about the last bastion of the free enterprise in the practice of medicine.

As previously stated, strengthening our organization is the most important thing we can accomplish today. Doctors must get together and coordinate both within the small societies and within the large ones. Many of us are too lackadaisical and take the attitude that the monster is already upon us; so sit tight and let fall what may. This is not true. We are a group dedicated to the upkeep and betterment of the health and welfare of the people of Georgia. This is a basic premise and an irrevocable obligation. I hereby send out a plea and urge all doctors to combine their efforts in maintaing our high standards, and at the same time improve our intra-professional and extra-professional (public) relationships.

The council, Executive Committee, and the fine outstanding staff of the MAG do not comprise a big balloon which suspends our organization. The component societies and district societies are the supports, basic foundations and the reason for the existence of the operational section of the MAG. Our staff puts out every effort to keep each individual doctor informed. Any communication in connection with or in relation to the MAG should be recognized and not thrown into the "round file." It is the obligation of each of us to be aware of activities concerning us and our relationship to the public. Take a little more time to discuss these things with your contemporaries—doctors, classmates, and friends (most patients should be friends). Do not treat medical communications lightly. Every one has some importance. The AMA news letter is very informative but not the total answer. Let us pay attention to our Georgia information and take action to improve our medical fraternity by sincere dedication and exert every effort to give ourselves a better public image.

We need a feeling of community effort. Who is going to do what for whom? You cannot build a little island unto yourself—coordinate. Free enterprise, integrity and morality rely on inter-relationship. Everyone has a desire beyond survival—to be wanted. "The higher a man is on the professional ladder, the less power more money will have as an activator. Most top-ranking professional men can be motivated best by challenges through which they can satisfy their social needs, their self-esteem, and their self-realization." We are in a challenging time and we are in competition with forces foreign to our desired way of life. We must not only maintain, but set our standards higher.

Procrastination may be the thief of time, but if we put off our organizational

obligations, we will lose more than time. Prove the existence of our beliefs and remember what Sir William Osler said, "faith—the one great moving force which we can neither weigh in the balance nor test in the crucible."

Charles R. Andrews Jr. M.D.

Charles R. Andrews, Jr., M.D.
President, Medical Association of Georgia

GEORGIA ABORTION ACT BECOMES LAW

In 1968 the General Assembly of Georgia passed a bill commonly referred to as the "Georgia Abortion Act." Now that the Act has become law, it provides for the lawful performance of abortions in carefully prescribed and specifically documented cases.

Attorneys for the Medical Association of Georgia and the Georgia Hospital Association have developed appropriate forms for compliance with the required documentation and these are acceptable to the Director of the Georgia Department of Public Health for filing, in accordance with the law.

The Department will be expected to collate and interpret data in order to report to the Governor or the legislature, or both, at their call. Properly prepared, the Certificate of Fetal Death will give sufficient medical information for this required reporting. The following explains the requirement and suggests the manner in which the certificate might be completed. Copies of this have been forwarded to the Georgia Hospital Association for transmittal to the hospital administrators.

Therapeutic abortion results in the death of the fetus. Fetal death is defined in the Georgia Health Code, December 1964, Section 88-1702 as:

(f) "Fetal death" means death prior to the complete expulsion or extraction from its mother of a product of human conception, irrespective of the duration of pregnancy. The death is indicated by the fact that after such expulsion or extraction the fetus does not breathe or show any other evidence of life, such as beating of the heart, pulsation of the umbilical cord, or definitive movement of voluntary muscles.

A Certificate of fetal death is required by the Georgia Health Code:

88-1716. Fetal death registration; requirements: (a) A fetal death certificate for each fetal death which occurs in this State shall be filed with the local registrar of the registration district in which the delivery occurred within 72 hours after such delivery and shall be filed with such registrar if it has been completed in accordance with this section: Provided, (1) that if the place of fetal death is unknown, a fetal death certificate shall be filed in the registration district in which a dead fetus was found within 72 hours after such occurrence and (2) that if a fetal death occurs on a moving conveyance, a fetal death certificate shall be filed in the registration district in which the fetus was removed from such conveyance.

THE ORIGINAL CERTIFICATE OF FETAL DEATH WILL BE FILED AS REQUIRED, AND A COPY WILL BE ATTACHED TO THE SET OF FORMS AND CERTIFICATES TRANSMITTED TO THE DIRECTOR, GEORGIA DEPARTMENT OF PUBLIC HEALTH.

The following entries in Item 27 of the Certificate of Fetal Dealth would be appropriate and are based on the eighth Revision of the International Classification of Diseases, 1963.

A. For those cases where the termination is for medical indications, maternal or fetal:

27(a) "773 Termination of pregnancy—abortion" due to

27(b) "640 Abortion induced for medical indications" due to

27(c) Herein would be entered the diagnosis of maternal or fetal disease or injury which is the underlying medical indication for the therapeutic abortion. Several examples are given below. Other appropriate terminology and diagnosis may be used.

"056 Rubella"
"174 Malignant Neoplasm of Breast"
"295 Schizophrenia (type)"
"977 Adverse Effects of other drugs"

B. In the event of rape the following entries would be appropriate:

27(a) "773 Termination of pregnancy—abortion" due to

27(b) "641 Abortion induced for other legal reasons"

(There is no need for any entry in 27(c) since rape is not a medical diagnosis, and it is considered that the use of this term in the report would be unnecessary and might be a cause of embarrassment to the patient.)

C. In Item 27 "Other significant conditions" may be used to add additional information.

BOARD REVOKES PHYSICIAN'S LICENSE FOR INCOMPETENCY

JOHN L. MOORE, JR., ***Atlanta****

An interesting and hard fought case was finally decided at the end of January, 1968, by the Supreme Court of Kansas.

Dr. Foote graduated from Harvard Medical School in 1938. His subsequent training included internships and residencies at various hospitals, naval service as a medical officer, and private practice for 12 years in a rural community in Pennsylvania. Two other surgeons opened a hospital in the Pennsylvania community and cut his income in half. A few months later he moved to a hospital at Topeka where for a year he did much general surgery. He then went to a clinic with the understanding that if after one year it was mutually satisfactory, he would be taken into the staff. However, he did not go on the staff there. He then moved to Beloit, Kansas. Dr. Foote was certified by the American Board of Surgery in 1949 and became a fellow in the American College of Surgeons in 1950.

When he moved to Beloit he applied for membership on the staff of the public hospital there. The hospital staff made inquiries. One reply stated that "his preoperative judgment was poor and his postoperative care was bad, and that they would not recommend him as a surgeon." Another institution refused to put an opinion in writing but stated on the telephone "not to let him do major surgery, not to let him operate on his family, and if he was in the operating room he should be supervised." Dr. Foote presented to the staff two letters in his favor. The staff of the hospital voted ten to one against his admission to the staff. The only one voting for him was a doctor in his eighties who later assisted in Dr. Foote's surgery. Dr. Foote was admitted to the staff pursuant to court order. He then tried not to comply with the hospital rule requiring an assistant for major surgery.

The review committee at the hospital raised serious questions as to specific cases and complaint was brought to the State Board of Healing Arts which, after a hearing into the different cases, removed Dr. Foote's Kansas license to practice medicine on the grounds of incompetency.

Case Histories

The decision of the Supreme Court of Kansas mentions 11 different cases, greatly summarized. Room is not sufficient in this article for repeating all of the cases. However, three or four of the more serious ones will illustrate the point.

** Prepared at the request of The Medical Association of Georgia. Mr. Moore is a member of the firm of Alston, Miller & Gaines, General Counsel to the Medical Association of Georgia.*

Case discussed is Kansas State Board of Healing Arts v. Foote, Supreme Court of Kansas, 436 P. 2d. 828.

Dr. Foote removed a patient's gall bladder, transecting the cystic duct and leaving it open. Instead of tying it, he tied the common duct running into the abdomen below the cystic duct stump, forcing bile into the abdominal cavity and causing acute bile peritonitis from which the patient died eight days later. During the time following the operation that the patient's condition had abruptly and obviously worsened, Dr. Foote made no reexploration to find the cause of difficulty and did not seek consultation with another doctor until shortly before the patient's death.

Dr. Foote operated on a 68-year-old man for incarcerated femoral hernia. The patient had a history of emphysema. Dr. Foote caused the patient to be given a general pentothal induction and gas ether anesthesia. The patient requested that he be allowed to go home and Dr. Foote released him after giving him tranquilizers. At the time of release, the patient had a high temperature and pulse rate and x-ray showed that he had pneumonitis. He was not given any antibiotics and he died within 48 hours of release. On his death certificate Dr. Foote indicated cardiac failure as the cause of death.

A 38-year-old woman was admitted to the hospital with diagnosis by Dr. Foote of tubal abortion. No pregnancy tests were made. He operated and found a normal two and one-half month pregnancy. He removed the appendix. A month later he readmitted the patient with diagnosis of incomplete abortion. He scheduled her for elective dilatation and curettage and scraped out a fresh fetus with placenta tissue and fragments. A pathologist did not substantiate Dr. Foote's report that amniotic fluid was observed and necrotic placenta tissue obtained.

A frail lady aged 73 years was admitted to the hospital. Dr. Foote ordered an x-ray which he read. He did not see air under the diaphragm and made no definite diagnosis from the x-ray. He first diagnosed possible cholecystitis, later acute pancreatitis. The patient died two days after admission. A radiologist, who had been available earlier but not used, read the x-ray as showing a large collection of free air in the right upper quadrant secondary to a perforated viscus, probably a duodenal ulcer. The autopsy report showed a perforated ulcer.

Court Proceedings

As indicated above, the Kansas State Board of Healing Arts removed Dr. Foote's license to practice medicine and surgery on the basis of extreme incompetency. Dr. Foote appealed to the District Court which reversed the Board's revocation of a medical license.

The Supreme Court of Kansas reversed the District Court and reinstated the order of the State Board of Healing Arts revoking Dr. Foote's license. In doing so, the Supreme Court of Kansas had to deal with a statute which did not specifically provide for the removal of a license for incompetency. However, the Supreme Court of Kansas said:

> "No conduct or practice could be more devastating to the health and welfare of a patient or the public than incompetency; integral to the whole policy that the legislature had in mind must be the power of the board to protect against it."

Comment

This case illustrates the increasing tendency of courts to compel hospital staffs to admit any licensed physician to staff membership, at least if the hospital is the only public hospital in the community. If this be so, it is extremely important that the courts protect the public against incompetency in the way done in the case discussed. It is interesting to note at the same time that the AMA Legal Department advises that the Attorney General of Michigan, construing a similar statute, has reached a contrary conclusion as to the revocability of a license for incompetency.

ADEQUATE CANCER EXAMINATION

A. H. LETTON, M.D., *Atlanta**

BREAST, UTERINE AND COLON-RECTAL CANCER are being "cured" in more than 65 per cent of the cases when treated while still localized. These three sites account for 89,000 deaths and 182,000 new cancer cases annually in the United States.

In Georgia, 591 physicians have joined with the Professional Education Committee of the American Cancer Society in our efforts to "make every doctor's office a cancer detection center." They have ordered supplies of the leaflet to be given patients which outlines the committee's concept of an "adequate" cancer detection examination:

—examination of entire *skin*
—the *eyes* with an ophthalmoscope
—the *nose, mouth, throat*
—under all dentures
—palpation of the neck for enlargement of thyroid or other masses under arms and in groins for enlarged lymph nodes
—if any hoarseness, examine vocal cords with mirror
—listen to *heart* and *lungs*
—feel the *abdomen* for any abnormalities
—do a *rectal* as well as proctosigmoidoscopic examination
—do a *breast* and *pelvic* examination on females (including a PAP smear test)
—palpate the *testes* of the male
—get a *urinalysis* and complete blood count, and *X-ray* of the chest
—if there is any indigestion, X-ray intestinal tract
—if there is a lump in the breast, it should be biopsied
—if there is bleeding from the rectum, an X-ray of colon should be included

REMEMBER, cancer *in the early stages causes no pain* or *ill feeling.*

FIVE-YEAR SURVIVAL RATE

	Estimated New Cases 1968	Treated While Localized %	When Regional Involvement %	Estimated Deaths 1968
Skin Cancer	105,000	92		5,000
Uterus	44,000	81	46	14,000
Breast	65,000	82	47	28,000
Colon-Rectal	73,000	68	34	45,000
Kidney and Bladder	32,000	61	24	15,000
Oral Cancer (inc. Pharynx)	15,000	53	13	7,000
Prostate	35,000	50	30	17,000
Lung	61,000	21	5	55,000

* *Dr. Letton is Chairman, Professional Education Committee, American Cancer Society, Georgia Division.*

ARTIFICIAL CARDIAC PACEMAKERS

PAUL E. CUNDEY, JR., M.D., ***Augusta****

ARTIFICIAL PACING OF THE HEART became a clinical reality ten years ago, and during this past decade these pacemaking devices have greatly facilitated the management of symptomatic heart block. The main reason for insertion of a permanent cardiac pacemaker is to reduce the high mortality of patients who have had the Stokes-Adams syndrome. During this same period it has become clear that in the majority of patients with acquired heart block the conduction disturbance is not due to coronary artery disease. Rather, the pathological basis of the problem is commonly one of localized sclerosis involving both the right and left branches of the intra-ventricular conduction system. This pathological entity has been designated primary heart block. The elucidation of the pathological basis of this clinical problem has profound therapeutic implications. The majority of patients, then, with acquired complete heart block and syncopal attacks due to ventricular asystole are excellent candidates for long term artificial pacing, since myocardial function is often excellent.

Recently, attention has been directed toward the recognition of the patient population susceptible to developing symptomatic heart block. It has been demonstrated that patients with complete right bundle branch block and a left axis deviation are particularly prone to develop intermittent or complete heart block in subsequent years. Further, it is now quite clear that the appearance of intermittent heart block may precede syncopal episodes by months and even years. Recognition of these high risk patients should lead to earlier definitive therapy for patients who subsequently develop Stokes-Adams attacks. In this country alone, it has been estimated that ten thousand patients per year become candidates for long term artificial pacemaking. It is biologically predictable that this figure will increase as the proportion of the aged population increases.

A second situation in which an artificial cardiac pacemaker may be of benefit is in patients with acquired complete heart block and refractory congestive heart failure even if the patient has not had syncopal attacks. In this situation artificial

* *Dr. Cudey is a Fellow in Cardiology at the Medical College of Georgia.*
Prepared at the request of the Committee on Professional Education of the Georgia Heart Association.

pacing will produce an increase in ventricular rate and also in the cardiac output.

All permanent cardiac pacemakers have electrodes attached to the ventricular myocardium, and these electrodes are connected to a battery powered unit which is placed in the subcutaneous tissue on the thorax or upper abdomen. In the early years of pacemaking devices, clinical usage was plagued with technical complications. Initially, permanent pacing required the implantation of epicardial electrodes. The required thoracotomy resulted in a significant mortality and morbidity in this predominantly aged population. In addition, subsequent wire fracture was a common problem with this system. Improvements, however, in electrode design and mechanical characteristics have substantially reduced this complication in recent years. Battery longevity has been improved and nuclear powered pacemaker devices are now in the developmental process. More recently endocardial electrodes, inserted into the heart through the jugular vein, have had wide utilization. Utilizing these electrodes, the need for thoracotomy was obviated, and morbidity and mortality associated with the implantation procedure reduced. Electro-physiologic complications inherent in long term pacing, particularly that of sinus node competition, have been offset by the development of demand pacemakers. Demand pacemakers do not stimulate the heart until the ventricular rate falls below an acceptable level. The early clinical results utilizing these devices indicate a significant reduction in competition problems associated with the permanent rate units.

The clinical usage of prosthetic pacemaking devices can be expected to increase. The bio-technical problems associated with the usage of such devices are steadily being eliminated. These prosthetic pacemaking devices offer to the patient with symptomatic heart block a significant therapeutic advantage over previous forms of therapy.

Medical College of Georgia

Doctor . . . . Shouldn't You Contribute to the MAG Foundation?

- **Your Contribution Is Tax Deductible**
- **You May Earmark Funds**
- **You May Contribute Cash, Books, Life Insurance, Land, Instruments, Stamp and Coin Collections, Works of Art, Securities, and the like.**

WHY Not Complete and Mail the Form of Bequest Today?

MAG FOUNDATION

Form of Bequest

I give and bequeath to the Medical Association of Georgia Foundation, Inc., 938 Peachtree Street, N.E., Atlanta, Georgia 30309, the sum of ..... dollars $ (.....) to be used by the Board of Trustees of the Foundation for

.....

(state purpose of gift if restricted)

Signed .....

THE ASSOCIATION

NEW MEMBERS

Barr, Robert E., M.D. Active—Flint	408 East Third Avenue Cordele, Georgia 31015
Boyett, James E., M.D. Active—Fulton	1603 Ware Avenue East Point, Georgia 30044
Espinoza, Francisco T., M.D. DE-2—Fulton	1209 Bilmore Drive, N.E. Atlanta, Ga. 30329
Gillespie, Eugene J., M.D. Associate—Fulton	1280 West Peachtree St., N.W. Atlanta, Ga. 30309
Kahn, S. David, M.D. Active—Fulton	1317 Clifton Rd., N.E. Atlanta, Georgia 30322
Melvin, Harvey A., M.D. Active—Fulton	3400 Peachtree Rd., N.E. Atlanta, Ga. 30326
Nelson, John W., M.D. Active—Bibb	Macon Hospital Macon, Ga. 31201
Tomas, Teofilo, M.D. Active—Baldwin	Central State Hospital Milledgeville, Ga. 31062
Wood, William E., M.D. Active—Baldwin	Central State Hospital Milledgeville, Ga. 31062

SOCIETIES

Dr. Carl Pittman, Jr., of Tifton, was elected president of the **Second District Medical Society** at the April meeting held in Moultrie. Other new officers include Charles Watt of Thomasville, vice president, and W. P. Stoner of Sylvester, secretary-treasurer.

The **Georgia Medical Society** commended Mills B. Lane for his proposed "Savannah Plan" for the rehabilitation of deteriorated neighborhoods. In a letter from society president Dr. Thomas A. McGoldrick, Jr., the society offered its support and assistance for the clean-up phase of the plan. Dr. McGoldrick stated that local doctors "have been concerned for some time with the hazard to community health that might result from rubbish and accumulation and from overcrowding in sub-standard dwellings."

PERSONALS

First District

L. H. Griffin, Sr., State Board of Health member for Claxton, was recently honored by his many friends from Evans and surrounding communities for his "years of unselfish service" to the people of the area.

Second District

Warren C. Baxley of Blakely was a member of a team of doctors who spent ten days in Honduras, Central America, as part of the Brother's Brother Foundation to participate in a mass immunization program. Mrs. Baxley accompanied Dr. Baxley, also as a volunteer.

William M. Newton, Jr., of Moultrie and **T. D. Johnson** of Albany participated in a Paramedical Personnel Symposium held at the Dougherty County Health Center in April.

Third District

Dr. and Mrs. **W. G. Elliott** of Cuthbert attended the 67th annual meeting of the Association of Surgeons of the Southern Railway System held April 22-24 in Cincinnati, Ohio.

Fourth District

Harper Butterworth, president of the Fourth District Medical Society, has been chosen to serve on the "Task Force for Physicians Manpower of the Georgia Comprehensive Health Planning Council."

Zeb V. Morgan of Decatur was appointed to the DeKalb County Economic Opportunity Authority, due to the resignation of Timothy Harden.

James L. Clements, Jr., of Newnan has been named Fellow in the American College of Radiology. Other new Fellows include **Robert L. Egan** and **Charles M. Silverstein** of Atlanta.

Fifth District

The main speaker at the May 7 meeting of the Fulton Kiwanis Club was **Albert K. Schoenbucher,** director of maternal health service, State Department of Public Health. Dr. Schoenbucher discussed the State Health Department's maternal health programs which are designed to provide the medically indigent woman adequate prenatal and postpartum care, the family planning program and the cervical cancer detection program.

The Epilepsy Foundation of America announced the formation of its first Professional Advisory Board. Among the members of the board is **Herbert Karp,** head of the Department of Neurology at Grady Memorial Hospital.

Bernard L. Hallman, associate dean for professional services at Emory University, was appointed associate dean in charge of coordinating community programs, including the Atlanta Comprehensive Neighborhood Health Program and the Regional Medical Program. The medical school also announced the appointment of **Douglas B. Kendrick,** professor of surgery and medical director at Grady, to the position of associate dean for professional affairs at Grady, replacing Dr. Hallman in that post.

The Elks Aidmore Hospital in Atlanta announced the

appointment of **Mary Z. Skorapa** as Medical Director of the hospital.

Thomas L. Tidmore, Jr., has been elected president of the Atlanta Association for Retarded Children. Dr. Tidmore succeeds Dr. Walter C. Earle.

Lamar Peacock has been elected president of the Medical Staff at Georgia Baptist Hospital.

Charles D. Smithdeal of Emory University School of Medicine has been elected a Fellow in the American Academy of Facial Plastic and Reconstructive Surgery.

Sixth District

Homer S. Nelson of Macon, has recently returned from two years in the Air Force and has resumed his practice in ophthalmology with **W. Devereaux Jarratt.**

Z. Sweeney Sikes was featured in an article in the *Macon News* about the opening in May of the College Street Hospital, Inc. Dr. Sikes, president of the corporation which owns middle Georgia's only private psychiatric hospital, was a central figure in bringing additional psychiatric facilities to Macon.

A. M. Phillips, Jr., of Macon, has been named a Fellow in the American Academy of Orthopaedic Surgery.

New officers of the Middle Georgia Hospital include **Charles R. Ireland,** president; **T. E. Rogers, Jr.,** vice-president; and **Jack Menendez,** secretary.

James B. Craig, of Milledgeville, has been elected a Fellow of the American College of Psychiatrists.

Seventh District

Robert Sessions, of Marietta, was elected president of the Cobb-Douglas-Paulding Tuberculosis Association. The announcement was made at the Association's annual membership meeting in April.

Eighth District

The American Academy of Pediatrics has selected **Newell M. Hamilton** of Brunswick, to serve as a Head Start consultant in Georgia. Dr. Hamilton is one of approximately 525 physician consultants named by the AAP to evaluate medical aspects of Head Start programs in nearly 2,000 communities in the country.

Avery Cotton has recently joined **Robert H. Thompson** at the Parkwood Medical Center in Brunswick. Dr. Cotton formerly practiced in Atlanta.

Robert B. Quattlebaum of Valdosta is serving a two-month voluntary tour aboard the hospital ship SS HOPE in Colombo, Ceylon.

New officers of the Glynn-Brunswick Memorial Hospital include **W. O. Inman,** chief-of-staff; **John Hobson,** vice chief-of-staff; and **William Austin,** secretary.

Ninth District

The Georgia Association for Mental Health announced the election of **Ben T. Looper** of Canton to a two-year term on the board. The election took place at the Association's annual meeting in February.

Tenth District

Walter G. Rice, dean of the Medical College of Georgia, was named director of the division of operational studies of the Association of American Medical Colleges.

W. C. McGeary, Jr., of Madison, attended a medical seminar at Dublin, Georgia, on May 2. The program was presented by **John Venable,** Director of the Georgia Department of Public Health, **J. Gordon Barrow,** Director of the Georgia Regional Medical Program, and **Glen E. Garrison,** Professor and Chairman of the Department of Community Medicine at the Medical College of Georgia.

John B. O'Neal of Elberton was elected to the board of the Georgia Association for Mental Health. Dr. O'Neal will serve a one-year term.

The Board of Trustees of the Wood Library-Museum awarded a plaque of appreciation to **Perry P. Volpitto,** for "devoted service to the aims and ideals of the Wood Library-Museum of Anesthesiology."

DEATHS

Robert Battey Crichton

Dr. Robert Battey Crichton, 74, of Augusta, died May 4 after an extended illness. Dr. Crichton, a native of Rome, Georgia, had lived in Augusta for two years.

A retired medical doctor, Dr. Crichton was a graduate of Emory University Medical College, and had done post graduate work at the old Lying-In Hospital in New York, and at Margaret Hague Hospital in New Jersey.

Dr. Crichton served on the staff of Milledgeville State Hospital for four years, and at State Hospital in Columbia, S.C. for four years. He also maintained a private practice.

Dr. Crichton was a member of the Richmond County Medical Society, the Medical Association of Georgia, and the American Medical Association, and was a former member of the American Psychiatry Association. He was also on the staff of University Hospital and St. Joseph Hospital.

Survivors include his wife, Mrs. Sarah Alexander Crichton of Augusta; a sister, Mrs. Catherine Symmes of Atlanta; a nephew, John Symmes, of Atlanta, and four great-nieces.

MENTAL HEALTH CENTER TO SERVE SIX AUGUSTA AREA COUNTIES

A $1.6 million community mental health project has been approved for Augusta, and when in full operation will give the Richmond county area "one of the best mental health programs in Georgia," according to Dr. John H. Venable, director of the Georgia Department of Public Health.

The comprehensive program—to be financed by $821,104 in U.S. Public Health Service funds, and an equal amount in local matching funds—will bring across-the-board mental health care to patients from six counties: Richmond (Augusta), Lincoln, Wilkes, Burke, McDuffie and Columbia.

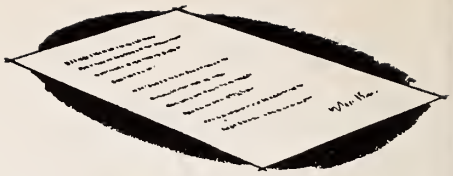
Dr. Venable said that the project, which will be jointly operated by Talmadge Memorial Hospital, the University Hospital in Augusta and the Richmond County Health Department, will provide six basic mental health services: in-patient and emergency care (104 beds at Talmadge Memorial), out-patient treatment, partial hospitalization, consultation and public education, and after-care services (all provided by the University Hospital).

COUNTY MEDICAL SOCIETIES OF GEORGIA

MEDICAL SOCIETY	PRESIDENT	SECRETARY	MEETING DATE
Altamaha	J. A. Bedingfield, Baxley	H. L. Morgan, Baxley	2nd Wed.
Baldwin	Mahmud Majanovic, Milledgeville	L. J. Jacobs, Milledgeville	
Barrow	G. R. Parkerson, Winder	R. F. Graves, Winder	1st Fri.
Bartow	R. A. Griffin, III, Cartersville	W. C. Holmes, Cartersville	Quarterly
Ben Hill-Irwin	W. C. Sams, Ocilla	Roy Johnson, Jr., Fitzgerald	
Bibb	R. G. Newton, Jr., Macon	S. C. Neuberg, Macon	1st Tues.
Blue Ridge	H. E. Mitzelfeld, Blue Ridge	James Haymore, Blue Ridge	
Bulloch-Candler-Evans	C. G. Hames, Claxton	L. E. Curry, Metter	2nd Tues.
Burke	J. M. Byne, Jr., Waynesboro	C. G. Green, Sr., Waynesboro	1st Tues.
Camden-Charlton	J. M. Jackson, Folkston	H. H. Robinson, Kingsland	1st Mon.
Carroll-Douglas-Haralson	W. S. Worthy, Carrollton	E. H. Grant, Carrollton	1st Mon.
Georgia Medical Society	T. A. McGoldrick, Jr., Savannah	J. J. Holloman, Savannah	2nd Tues. except summer
Chattahoochee	F. A. Sims, Jr., Lawrenceville	Harry Hutchins, Buford	
Cherokee-Pickens	E. A. Roper, Jasper	A. M. Hendrix, Canton	3rd Fri.
Crawford W. Long	Royce Banister, Athens	W. J. Hardman, Jr., Athens	Quarterly
Clayton-Fayette	E. W. Abernathy, Jr., Jonesboro	F. A. Sams, Jr., Fayetteville	3rd Tues.
Cobb	L. G. Fortson, Jr., Marietta	W. T. Williams, Smyrna	1st Tues. after 1st Mon.
Coffee	T. L. Parker, Douglas	W. R. Wills, Jr., Douglas	3rd Tues.
Colquitt	R. M. Joiner, Moultrie	R. E. Fokes, Moultrie	2nd Mon.
Coweta	H. C. Glover, Newnan	F. D. Bass, Newnan	3rd Tues.
Decatur-Seminole	H. H. McNair, Bainbridge	M. A. Ehrlich, Bainbridge	
DeKalb	H. H. Butterworth, Decatur	F. E. Morgan, Jr., Decatur	3rd Mon.
Dougherty	F. D. Guillebeau, Albany	Allen Turner, Albany	
Emanuel	H. W. Smith, Swainsboro	C. E. Powell	2nd Mon.
Flint	O. K. Coleman, Cordele	C. C. Goss, Ashburn	4th Mon.
Floyd	Russell Andrews, Rome	H. R. Connell, Rome	Quarterly
Elbert-Franklin-Hart	L. G. Cacchioli, Hartwell	A. S. Johnson, Jr., Elberton	Quarterly
Fulton	L. H. Bishop, Jr., Atlanta	F. W. Dowda, Atlanta	Monthly on Tues.
Glynn	W. E. Harden, Brunswick	W. A. Snyder, Brunswick	3rd Tues.
Gordon	J. L. Raab, Calhoun	Bill Purcell, Calhoun	
Grady	W. J. Morton, Cairo	S. L. Hancock, Cairo	
Habersham	Bruce Swain, Cornelia	J. B. Edwards, Cornelia	Upon Call Quarterly
Hall	J. K. Burns, III, Gainesville	E. E. Estes, Jr., Gainesville	2nd Mon. except summer
Peach Belt	H. E. Sims, Fort Valley	E. B. Meserve, Warner Robins	
Jackson-Banks	J. L. Griffeth, Commerce	A. A. Rogers, Jr., Commerce	3rd Tues.
Jasper	J. H. Prichett, Jr., Monticello	B. C. Barrow, Monticello	1st Tues.

Jefferson	J. W. Pilcher, Louisville	C. R. Williams, Wadley	Upon Call
Jenkins	A. P. Mulkey, Millen	W. W. Hillis, Jr., Millen	2nd Tues.
Lamar	J. H. Jackson, Barnesville	S. B. Traylor, Barnesville	
Laurens	R. M. Glover, Dublin	Jaime Franco, Dublin	Quarterly
McDuffie	J. W. Lemley, Thomson	T. W. Middlebrooks, Thomson	3rd Mon.
Meriwether-Harris	Edward Haak, Warm Springs	J. L. Robinson, Woodbury	
Mitchell	J. C. Brim, Pelham	A. A. McNeill, Camilla	Last Fri.
Muscogee	C. D. Johnson, Columbus	D. M. Stewart, Columbus	4th Tues. except summer
Newton-Rockdale	R. L. Faulkner, Covington	E. J. Callaway, Covington	3rd Tues.
Oconee Valley	H. A. Thornton, Greensboro	L. J. Wade, Union Point	2nd Thur.
Ocmulgee	Hart Sylvester, Hawkinsville	W. E. Coleman, Hawkinsville	
Polk	T. E. Cummings, Rockmart	J. F. Atha, Rockmart	
Rabun	J. C. Dover, Clayton	Richard J. Turner	2nd Mon.
Randolph-Stewart-Terrell	C. R. Sheffield, Dawson	Mark Allen, Dawson	
Richmond	S. H. Prather, Jr., Augusta	C. S. Mulherin, Augusta	4th Tues. except summer
Screvens	K. R. Hawkins, Sylvania	G. B. Hogsette, Sylvania	2nd Tues.
South Georgia	Harry Mixon, Valdosta	Henry Sherman, Valdosta	
Southeast Georgia	H. I. Conner, Vidalia	G. P. Sassos, Mount Vernon	
Southwest Georgia	James H. Crowdis (1968), Blakely	R. E. Jennings (1968), Arlington	Bimonthly except summer
Spalding	Arthur Krepps, Griffin	Carlos Zevallos, Griffin	3rd Tues.
Stephens	Carlos Barroso, Toccoa	Ken Conoley, Toccoa	Last Tues.
Sumter	J. H. Robinson, Americus	W. R. Anderson, Americus	
Taylor	F. H. Sams, Reynolds	E. C. Whatley, Reynolds	
Telfair	F. R. Mann, Jr., McRae	D. B. McRae, McRae	Last Fri.
Thomas-Brooks	D. J. McKenzie, Thomasville	F. G. Osborne, Thomasville	Upon Call
Tift	T. L. Edmondson, Tifton	P. W. Lucas, Tifton	1st Mon.
Tri-County	F. T. Robbins, Hinesville	W. D. Fraser, Hinesville	2nd Tues.
Troup	G. A. McCrary, LaGrange	E. A. Prieto, LaGrange	
Upson	L. L. Allen, Jr., Thomaston	J. E. Mikell, Thomaston	
Walker-Catoosa-Dade	Gordon Hixson, Ft. Oglethorpe	W. D. Crawley, Rossville	
Walton	P. J. Enslen, Monroe	R. M. Tankesley, Monroe	4th Mon.
Ware	O. R. Wilson, Alma	J. W. Bickerstaff, Waycross	1st Tues.
Washington	M. W. Hurt, Sandersville	D. L. Holmes, Sandersville	
Wayne	R. A. Pumpelly, Jesup	E. L. Harrell, Jesup	2nd Mon.
Whitfield	A. N. Boozer, Dalton	Thomas Carey, Dalton	
Wilkes	C. E. Pollock, Washington	A. D. Duggan, Washington	2nd Tues.
Worth	F. L. McLean, Sylvester	R. T. Morgan, Sylvester	3rd Tues.

ABSTRACTS BY GEORGIA AUTHORS



Kaufman, Leo, Ph.D. and Blumer, Sharon, M.S., National Communicable Disease Center, Atlanta, Ga., "Development and Use of a Polyvalent Conjugate to Differentiate Histoplasma capsulatum and Histoplasma duboisii from Other Pathogens," Journal of Bacteriology 95:1243-1246(April)1968.

The fluorescent antibody (FA) technique is used for the detection and identification of the yeast form of *Histoplasma capsulatum* in culture, sputum samples and in other types of clinical material. Recent investigations, employing the FA technique, have demonstrated the existence of five serotypes of *H. capsulatum*. These investigations also revealed that the available specific FA reagents stained only four of these five serotypes.

In order to develop a reagent specific for *H. capsulatum* and reactive with all the known serotypes, antibodies were produced against the most complex *H. capsulatum* serotype and labeled with fluorescein isothiocyanate. The unadsorbed reagent not only stained all the *H. capsulatum* serotypes, but it also stained cultures of *Blastomyces dermatitidis, H. duboisii,* several *Candida* species, and a variety of other fungi. Adsorption of the conjugate with antigens of *C. albicans* produced a reagent that intensely stained only *H. capsulatum, H. duboisii,* and *B. dermatitidis*. Differentiation of *B. dermatitidis* from the *Histoplasma* species was accomplished by application of a *B. dermatitidis* specific fluorescent antibody to antigens positive with the *H. capsulatum* reagent.

At present, differentiation of *H. capsulatum* from *H. duboisii* may be accomplished only by animal inoculation. Our data substantiate the antigenic relationships hypothesized earlier, and they indicate that *H. capsulatum* shares at least two antigens with the other fungi that were studied.

Shepard, Charles C., M.D., Tolentino, Jose G., M.D. and McRae, Dorothy H., B.Sc., "The Therapeutic Effect of the 4,4'-Diacetyldiamino-Diphenyl-Sulphone (DADDS) in Leprosy," National Communicable Disease Center, Atlanta, Ga., Am. Journal of Tropical Medicine and Hygiene 17:192-201(March)1968.

4,4'-Diaminodiphenylsulfone (DDS dapsone) had previously been shown to be active in very small dosages against *Mycobacterium leprae* in mice. Also, the di-acetylated derivative, DADDS, had been shown to act as a repository compound when injected intramuscularly. Consequently DADDS was studied for its efficacy in human leprosy. It was given in a dosage of 225 mg every 77 days to a group of ten patients, who were matched with a group of ten patients given oral DDS in a dosage of about 100 mg per day.

Two chief criteria of therapeutic response were employed: Reduction in numbers of *M. leprae* in nasal washings; and reduction in the ratio of solidly staining *M. leprae* in skin smears. Both criteria are thought to measure reduction in viability of the bacilli. By both measurements, DADDS was as active as DDS. There were two deaths in the group receiving DADDS, but these were not thought to be connected with drug toxicity.

The urinary output of sulfone in the DADDS patients, which averaged 1.6 mg per 24 hours, represented the absorption of about 2.4 mg DDS per day, and was estimated to have produced constant blood and tissue levels that were several times the minimal inhibitory concentration.

Sudia, W. D., Ph.D., Chamberlain, R. W., D.Sc. and Coleman, P. H., Ph.D., National Communicable Disease Center, Atlanta, Ga., "Arbovirus Isolations from Mosquitoes Collected in South Alabama, 1959-1963, and Serologic Evidence of Human Infection," American Journal of Epidemiology 87:112-126(January) 1968.

A total of 90,509 mosquitoes was collected at two adjacent areas in southwestern Alabama between 1959 and 1963 and tested for arbovirus infections. Fifty-eight arbovirus isolations were made, including strains of Eastern encephalitis, Western encephalitis, California encephalitis, Tensaw and Flanders viruses. *Culiseta melanura* was the species primarily infected with the Eastern and Western encephalitis and Flanders viruses. *Anopheles crucians* played a similar role in respect to Tensaw virus.

The prototype strain of a newly recognized virus, Tensaw virus, was obtained in this study. Also, the California group virus isolates are the first recorded from Alabama.

Stamm, Donald D., DVM, National Communicable Disease Center, Atlanta, Ga., "Arbovirus Studies in Birds in South Alabama, 1959-1960," American Journal of Epidemiology 87:127-137(January)1968. (Author deceased.)

Wild birds were captured periodically from a south Alabama area between November, 1959-December, 1960 by means of Japanese mist nets. The birds were banded, bled from the jugular vein, and released. Many were subsequently recaptured one or more times.

A total of 65 virus isolations was made from 3,020 blood samples tested, 42 of Eastern encephalitis virus and 23 of Western encephalitis virus. All of the isolations were from birds sampled between the months of September and December.

The results of serologic tests of 2,176 birds confirmed that little or no virus activity occurred in the area from January through July, 1960. A high antibody rate for both viruses developed from September to December. The highest proportions positive occurred in the permanent resident species, followed by winter resident, summer resident, transient and unstable species. Possible involvement of the transient species in southward transport of these viruses is indicated.

Ridley, John H., Atlanta, Ga., "The Histogenesis of Endometriosis, a Review of Facts and Fancies," Obstetrical and Gynecological Survey, 23 (January)1968.

The fact of the histogenesis of endometriosis is now acceptable. Endometrial tissue of the human is unique for several reasons: few tissues in the human body undergo such marked morphologic changes in such short periods of time and a benign tissue behaves in many respects as does a malignant tissue. It has been proven that shed or desquamated endometrial tissue may migrate to ectopic areas of the body of the host and in those locations continue to grow and behave in a manner similar to its behavior within the uterine cavity. These live cells migrate transtubally into the peritoneal cavity and cause endometriosis; these cells may be carried by benign metastasis via the lymph and blood channels and cause endometriosis in adjacent tissues and by mechanical or direct transplantation develop endometriosis in new sites.

In these modes, benign endometrial tissue may behave in a manner similar to adenocarcinoma of the endometrium, but here the similarity ends, because in the newer locations the benign cells continue to grow in an orderly fashion. These ectopically located cells continue to be influenced by the hormones of the body as does the endometrium of the uterine cavity, but in these newer locations can cause within the host signs and symptoms which are more clearly understood and more definitely treated as time passes. Therefore, Sampson's theory (now fact) of the histogenesis of endometriosis is a part of the whole picture which includes the phenomena of benign metastasis, direct extension, and mechanical transplantation.

Other theories of the histogenesis of endometriosis, discussed and evaluated within this paper, have been tarnished by time, lack of proofs, contraindications, and doubts. These examples of ruminative thinking have long been a part of the interesting portrait of endometriosis. Investigation of this enigmatic condition must continue to uncover new facts of its origin and to further cut away the haze of theory.

It has been shown historically that endometriosis has likely been realized longer than heretofore documented. Al-

hough references are vague in that the word "endometriosis" was not coined until relatively recent times, nevertheless research indicates that the condition was probably recognized as early as 1835. This is not too surprising because it is logical to conclude that endometriosis could have occurred in any menstruating women, even among the ancients.

There have been recorded and discussed in varying detail, consistent with their importance, eleven theories of the histogenesis of endometriosis. Most of these are of interest only for historic reasons, but from these and with proven facts at hand, our understanding has become more clear. The theory of celomic metaplasia has become obsolete, lacking proof, either experimentally or clinically, and this proof is unlikely to be forthcoming. Therefore, it is not logical to assume that this theory of celomic metaplasia explains the presence of endometriosis anywhere.

The theory of induction of endometriosis by special filterable substances, present in the tissue of the host, possibly emanating from either living, dying or dead endometrial tissue, has created interest and further investigation in animals is being carried out. However, thus far the resulting tissue changes in the experimental animals are not acceptable as endometriosis. The final test remains as to whether this is truly endometriosis and can be, indeed, demonstrated in the human.

Various factors which influence the development of endometriosis have been discussed. A clear distinction is drawn between the histogenesis of endometriosis and etiologic factors which predispose to its development. Examples of these factors are obstruction of normal passages of the female genital tract forcing the abnormal locations of endometrial cells, by transtubal regurgitation or direct extension. These cells in ectopic locations are thus transplanted, in a sense, and not initiated in growth. Other factors such as hormones, inflammation, pregnancy, and race, have been discussed as influences not to be confused with histogenesis.

Myths die slowly, depending on how deeply they have become ingrained into the minds of students and investigators. To paraphrase the famous statement of General Douglas MacArthur: Old theories never die, they just fade away. Proven facts stand the test of time.

Egan, Robert L., M.D., and Fenn, Jimmy O., M.S., Section of Mammography, Dept. of Radiology, Emory U. School of Medicine, Atlanta, Ga., "Phantoms for Evaluating Mammographic Techniques and Roentgenographic Detail," Am. Journal of Roentgenology, Radium Therapy and Nuclear Medicine 102:936-940 (April)1968.

A phantom in roentgenography is an invaluable aid in setting up and evaluating x-ray techniques without the constant problem of patient variation. The more nearly the same as the part being studied, the more valuable the phantom. This is particularly critical in mammography where objects 20 to 40 times smaller than in general radiography must be resolved.

Small objects simulating breast structures and breast changes have been embedded in breast tissue which in turn has been permanently mounted in solid plastic.

An illustration of the method used in comparing film quality (resolving power) clearly indicates its reliability, reproducibility, adaptability and precision that requires only the ability of the observer to see and count.

Pittman, Frank S., III, M.D., Langsley, Donald G., M.D., and DeYoung, Carol, R. N., Grady Memorial Hospital, 80 Butler St., Atlanta, Ga., "Work and School Phobias: A Family Approach to Treatment," Am. Journal of Psychiatry 124:93-99 (May)1968.

Eleven cases of work phobia were studied. Nine included a history of school phobia, a common syndrome seen as the result of a child's anxiety at separation from a mother equally afraid of separation. Treatment for school phobia has been most successful when directed toward helping the mother to firmly allow the child to separate.

While rarely reported, work phobia is not uncommon. Work phobia is an acute, episodic anxiety state associated with leaving home and going to work. The typical work phobia gives a history of school phobia associated with anxiety at separation from a symbiotic relationship with an overprotective mother. As an adult he remains at home or chooses a wife with whom he can have a similar relationship. The wife permits or encourages him to stay home from work. Brief therapy, focusing on this relationship, has been successful in returning the man to work. Work phobia must be distinguished from work inhibition and success neurosis, which require a different treatment approach.

Lobel, Hans O., M.D., Kagan, Irving G., Ph.D. and Kaiser, Robert L., M.D., National Communicable Disease Center, Atlanta, Ga., "Evaluation of Parasitologic and Intradermal Tests for the Detection of Hookworm Infection," Am. Journal of Epidemiology 87:58-72(January)1968.

Three coprologic techniques were used for the detection of hookworm eggs in the stools of 525 high school students in a locality in south Alabama. The culture technique was nearly twice as sensitive as the salt-flotation or the formalin-ether concentration methods. The prevalence of hookworm infection was 47.8 per cent in the white male students and ranged between 15.9 and 22.4 per cent in the white female and the Negro male and female students.

A skin test antigen was evaluated by measuring wheal areas 15 minutes after intradermal administration of 0.05 ml of hookworm antigen and a diluent control, considering a reaction $\geqslant 1.0$ cm^2 as positive. The average sensitivity of the 40 micrograms N/ml antigen was 76 per cent. A positive correlation was observed between skin reactivity, sensitivity and hookworm burden. Thirteen of the 14 individuals (93 per cent) with a hookworm load exceeding 2,000 eggs per gram feces had a positive skin reaction. Observed race and sex variations in reactivity were largely due to differences in intensity of infestation. The specificity of the test, determined in a hookworm negative control group of Iowa high school students was 90.9 per cent, with little race or sex variation. In this study there was little evidence for the existence of cross reactivity between the hookworm antigen and the presence of intestinal helminths other than hookworm.

The skin test described may be used as a rapid screening techinque for detection of hookworm infection.

Davenport, Richard K., Ph.D. and Rogers, Charles M., Ph.D., Yerkes Regional Primate Research Center, Emory University, Atlanta, Ga., "Intellectual Performance of Differentially Reared Chimpanzees: I, Delayed Response," Am. Journal of Mental Deficiency 72:674-680 (March)1968.

Seven chimpanzees, separated from their mothers at birth and raised for two years in a restricted environment, were compared on spatial delayed response tasks to eight wild-born, enriched environment chimpanzees when both groups were between seven and nine years of age. Restricted *Ss* were initially inferior, but with experience, closely approached the wild-born performance level. Differences in performance between the groups, and delays and improvement with experience are explained in terms of relative differences and changes in task-oriented and non-task-oriented behaviors. Findings are related to learning problems and IQ test performance of human children reared in unstimulating environments.

Larose, James H., M.D., Dept. of Radiology, Grady Memorial Hospital, 80 Butler St., Atlanta, Ga., "Cavitation of Missile Tracks in the Lung," Radiology 90:995-998(May)1968.

An unusual phenomenon in several cases of gun shot wound to the chest is described. On roentgenologic examination, the missile track appeared to have a clear center in four of 62 cases.

This phenomenon was seen only after injury with low muzzle velocity, small caliber hand guns. It always occurred in the upper lung fields, and three of the cases showed partial opacification of the dependent pulmonary lobes. This was probably secondary to drainage of the center of the missile track into a bronchus. The fourth case demonstrated a "pulmonary air meniscus" and did not show partial opacification of any lobe, possibly because of the retention of the fibrous clot in the missile track with only a minimal amount of non-clotting plasma draining into the bronchial tree. The track cavity probably remains open secondary to varying degrees of track wall fibrosis and to a relatively negative intra-thoracic pressure caused either by atelectasis of an ipsilateral lobe or by a functioning thoracotomy tube.

This phenomenon should not be confused with pulmonary necrosis or secondary infection.

HIGHLIGHTS OF EXECUTIVE COMMITTEE OF COUNCIL MEETING, MAY 31-JUNE 1, 1968

This summary is being published so that the MAG membership may be advised in brief of the actions of the Association's Council and Executive Committee. It covers only major actions and is not intended as a detailed report. Full minutes of these meetings are available upon any member's request to the MAG Headquarters Office.

MAG Committee Appointments (Charles R. Andrews, M.D.)—Chapter IV, Section 3 of the Bylaws states in part: "The Executive Committee shall appoint all association boards and committees, including Chairmen, and shall nominate members for all Boards required by the laws of the State of Georgia. . . ."

Action: The Executive Committee appointed all Standing and Special Committees of MAG for 1968-69, and prepared this list for Council's confirmation as directed by the Bylaws.

(a) **Radiation Control Council**—This Council is a five member Board appointed by the Governor and composed of one representative each from MAG, Georgia Dental Association, Georgia Radiological Society, Associated Industries of Georgia, plus one member-at-large. The term of MAG's representative, Dr. John T. Godwin, Atlanta, expires July 1, 1968. The Executive Committee may submit two names and the Governor will select one.

Action: Executive Committee voted to submit the names of John T. Godwin, M.D., and John R. McLaren, M.D., both of Atlanta to the Governor for his selection of one.

(b) **Board of Health Title XIX Advisory Board**—The Board of Health has set up a 14-member Title XIX Advisory Board and seeks one MAG representative. Dr. Mauldin suggested Dr. Wilson, Chairman of the MAG Title XIX Committee.

Action: The Executive Committee appointed Joseph S. Wilson, M.D., Atlanta, to represent MAG on this Board.

Abner Calhoun Lectureship Fund (Mr. E. F. Smith)—Approval of an amendment to the Abner Calhoun Trust Agreement will be considered as one step toward transferring the duties of trustee from the C & S Bank to the MAG Foundation.

Action: The Executive Committee approved the execution of the amendment to the Trust Agreement as the first step in transferring the duties of trustee from the C & S Bank to the MAG Foundation.

Report on Military Medicare Consultation, May 8, 1968 (J. Rhodes Haverty, M.D.)—Brigadier General Norman E. Peatfield, of the Department of Defense Military Medicare office in Denver, visited MAG in connection with a meeting in Washington, D.C., and met with J. Rhodes Haverty, M.D., Mr. Edwin F. Smith and Mrs. Joyce Butler, MAG's Military Medicare Program Administrator. In addition to making inquiries into the progress of the program in Georgia, General Peatfield discussed the future of Military Medicare, including the possible addition of a dental program, which would increase the scope of MAG's participation.

Action: This matter was received for information.

Hart County Hospital (Mr. E. F. Smith)—Action taken as a result of Executive Committee's directives May 4 will be reported.

Action: The Executive Committee received as information a report that the Chairman of MAG's Hospital Activities Committee, Dr. Charles Cowart, is proceeding with correspondence designed to assist in bringing about a settlement of any dispute at Hart County Hospital involving the Medical Staff and the County Board of Finance.

Utilization Review Contract Proposal (John T. Mauldin, M.D.)—Action by the State Board of Health on MAG's proposal to assume the responsibility for utilization review of Medicaid claims, as well as the usual and customary certification presently being done by Travelers Insurance Company, will be reported.

Action: It was reported that MAG's proposal would be considered at the June meeting of the Board of Health.

John Hancock Proposed Utilization Procedure (John T. Mauldin, M.D.)—Copies of the proposed utilization review guidelines developed by the Medicare Administrator for John Hancock Insurance Company, will be reviewed in light of their propriety to perform this function.

Action: The Executive Committee determined they could not approve or disapprove the proposed procedure, and felt that medical opinion should be brought into every questionable claim. The Executive Committee determined that the proposed procedure would be an administrative review, and that a physician should review any claim before it is returned to the physician who rendered the care.

Health Department Study on Quality Standards for Lab Procedures in Physicians' Offices (Mr. E. F. Smith)—A complete copy of the Health Department's application for a Federal grant to study and establish laboratory standards will be displayed for comparison with Executive Committee's May 4 statement of policy: "that the position of MAG be at the present time that outside imposed quality control of laboratory work in physicians' offices would be impractical." However, with respect to the necessity for and the frequency of laboratory procedures, this utilization could and should be subject to individual review.

Action: The Executive Committee referred this matter to the Medical Review and Negotiating Committee with the request that they report back to the Executive Committee in July if possible.

Headquarters Building Expansion (Mr. E. F. Smith)—The Executive Committee will be brought up to date on progress on the Headquarters Office Building.

Action: Executive Committee reviewed various points which had been covered in negotiations with prospective lenders and voted to accept the offer as outlined by the Decatur Federal Savings and Loan Association.

The Executive Committee also took the following actions as a result of matters being referred to the Executive Committee by the 1968 MAG House of Delegates:

—Referred the matter for the need to improve

MAG's staff benefits program to the Finance Committee for recommendations.

—Authorized the President to appoint a committee to study a new award for outstanding public service for civic activity.

—Referred the matter of a need for closer liaison with Student American Medical Association Chapters in Georgia to the Medical Education Committee.

—Authorized the MAG staff to proceed with arrangements for a committee conclave in early September.

—Appointed an Ad Hoc Committee on Elections composed of J. W. Chambers, M.D., Chairman, George H. Alexander, M.D., and Fleming L. Jolley, M.D.

The Committee heard a report from President Andrews that the liaison committee meeting with a committee of osteopaths was making progress toward a delineation of osteopathic practice privileges.

The following actions were also approved by the Executive Committee:

—That letters be written to the Georgia Academy of General Practice and the specialty societies for suggestions on methods of receiving nominations for MAG awards.

—Approved a statement regarding registered nurses and emergency resuscitative measures as requested by the Georgia Heart Association.

—Approved the purchase of miniature cups for presentation to living past recipients of the Hardman Award and the purchase of plaques for the purpose of recording the names and dates of past presentations of the award for permanent record in the headquarters office.

HIGHLIGHTS OF COUNCIL MEETING, JUNE 1-2, 1968—ATLANTA

This summary is being published so that the MAG membership may be advised in brief of the actions of the Association's Council and Executive Committee. It covers only major actions and is not intended as a detailed report. Full minutes of these meetings are available upon any member's request to the MAG Headquarters Office.

Health Careers Council of Georgia (John T. Godwin, M.D.)—Health Careers Council of Georgia, Inc. Board Chairman John T. Godwin, will expand on his Allied Health Careers Committee's recommendations which were approved by the House of Delegates.

Action: The Council approved Dr. Godwin's report and voted to refer his request for financial contribution of $5,000 to the Finance Committee for study and report to the September meeting of the Council.

Emory-Grady Agreement (F. G. Eldridge, M.D.) —Special guests, Dean Arthur Richardson, Emory, and Medical Director Douglas Kendrick, Grady, have been invited to discuss with Council their Agreement, and Amendment to the Agreement, which involves all MAG members in those two institutions.

Action: Council adopted a clearly worded resolution for transmittal to Emory University and Grady Hospital which calls for: (1) the establishment of a partnership by the active staff of Grady Hospital; (2) representatives to be elected by the active staff on a secret ballot; and (3) a voice on the part of the partnership in the disposition of Medicare-Medicaid funds to Grady Hospital.

Catastrophic Liability Insurance (Henry S. Jennings, M.D.)—MAG Insurance and Economics Committee Chairman Jennings will report the results of the committee's investigation of "umbrella" liability coverage and the recommendation that the proposal of the First National Investors, Inc., be endorsed by MAG.

Action: The Council voted to endorse the "umbrella" liability coverage proposal as recommended by the Insurance and Economics Committee.

Statewide Cancer Registries (Robert R. Smith, M.D.)—GRMP Associate Director, Dr. Smith, will discuss pertinent problems re: cancer registries, including the need for legislation to grant legal immunity to physicians reporting information to GRMP, and the assumption by MAG of the fiscal responsibility for a project to supply information to be purchased from GRMP under government contract (to be reimbursed upon completion of the project).

Action: Council voted to request the MAG attorney to render an opinion regarding the liability of physicians cooperating by sending information to Cancer Registries including patients' names. Council also voted to accept the offer of the Georgia Chapter, American Cancer Society to underwrite the GRMP contract with the Federal government to produce a demographic survey.

Other Actions taken by the Council were as follows:

—Voted to establish a Discretionary Fund of $500 for the Executive Committee of Council.

—Approved the purchase of miniature Hardman Award Cups for presentation to living past recipients of the Hardman Award and the purchase of two plaques for display at the MAG Headquarters Office containing the names of Hardman Award recipients.

—Authorized the Treasurer to pay the first statement received from the architects for the preliminary drawings of MAG's office addition.

—Confirmed the MAG committee appointments as presented by the Executive Committee.

—Received and acted upon the 1968 House of Delegates actions presented by Speaker Harrison Rogers.

—Voted to announce immediately the nomination of J. Frank Walker, M.D., of Atlanta for Vice Speaker of the AMA House of Delegates at the 1969 AMA meeting in New York City.

—Received a report on the progress of formation of the Georgia State Association of Medical Assistants.

—Received an interesting report from Dr. P. K. Dixon, Chairman of the Board of Health, on the activities surrounding the Board's May meeting.

—Voted to accept the Glynn County Medical Society invitation to hold the MAG Annual Session at Jekyll Island in 1970, and deferred action on a Bibb County Medical Society invitation to meet in Macon in 1972 to the next House of Delegates.

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THE MONTH IN WASHINGTON

The American College of Radiology, defending the current use of x-rays by physicians, criticized published scare stories for causing unwarranted fears of x-ray examinations.

Dr. Richard H. Chamberlain, a spokesman for the college, said such articles as one in a recent issue of the *Ladies' Home Journal* distorted the facts in such a manner that it added up to "one of the most tragic things in medicine" by scaring people as to the possible effects of being x-rayed. Dr. Chamberlain said usage of x-rays by physicians in this country is "remarkably good."

"The risks to patients in the performance for medical x-ray examinations are vanishingly small," he said. "Diagnostic x-ray examinations do not endanger the health of patients, despite a few shrill claims to the contrary. We could cite millions of instances where x-ray examinations provide life-saving information to patients."

The college supported in testimony before the Senate Commerce Committee a radiation standards bill, proposed after reports of radiation leaks from color television sets.

"The public has the right to expect protection against harmful amounts of inadvertent exposure to radiation from the operation of electronic devices," Dr. Chamberlain said.

He added that much more is known today about the effects of radiation than about many other environmental contaminants. Although more needs to be learned about the effects of low levels of radiation, he said, "we do know with assurance that their potential for harm is very small."

"The real tragedy occurs when even a single person may be misled by a distortion of radiation hazards to refuse a needed diagnostic x-ray examination," he said.

Reclassification of Drugs

The Food and Drug Administration (FDA) has proposed new regulations for the classification of drugs found both safe and effective for their labeled uses in a survey of more than 3,600 prescription drugs.

The new procedures would open the way to increased competition within the drug industry by allowing firms to market drugs reclassified as "not new" or "no longer new" without submitting and awaiting approval of new drug applications (NDA) by the FDA.

A manufacturer that gets an NDA approval for a product has the right to market it exclusively. It is in effect an individual company license. Under the terms of the Food, Drug and Cosmetic Act, any medicine can remain in this "new drug" category regardless of how long it has been on the market.

The new proposal would set up a system for reclassifying the pre-1962 "new drugs" recognized as effective in the drug efficiency study being conducted for FDA by the National Academy of Sciences-National Research Council. The review, authorized by Congress in 1962, covers 3,690 drugs—every drug marketed in this country between 1938 and 1962. The drugs under review had been approved as "new drugs" solely on the basis of safety.

FDA announced that two drugs—metyrapone and metyrapone ditartrate—would be the first "new drugs" reclassified under the proposal. Both were found effective

for their recommended uses of testing the functioning of the pituitary glands. They are manufactured by CIBA Pharmaceutical Co.

In its second report to carry out recommendations of the study of every drug manufactured in the United States between 1938 and 1962, the FDA notified the manufacturer of a drug used in the treatment of severely painful menstruation to provide evidence within 60 days that the product is effective for conditions listed in its labeling. The drug Lutrexin, manufactured by Hynson, Westcott & Dunning, Inc., of Baltimore, is available on prescription only.

The FDA also has issued a new warning about dangers of the antibiotic drug chloramphenicol.

High Cost of Medicaid

Health, Education and Welfare Secretary Wilbur Cohen estimated that the medicaid program may cost the Federal government between $2.5 and $3 billion in the fiscal year 1971.

The estimate for the current fiscal year (1968) is $2.1 billion. The original estimate for the past year was $1.7 but that proved substantially low and the administration has asked for $500 million more.

Congress has put some restrictions on the medicaid program, effective this July 1, and they may result in holding down the 1971 costs below Cohen's estimate.

The Social Security Administration reported that the medicare Part B program, physicians' services, operated at a small deficit in fiscal 1967 which will be covered by the increases from $3 to $4 in monthly premiums.

The percentage of people 65 and over enrolled in the doctor bill insurance part of medicare went up from 92 to 95 per cent during the 6-month open enrollment period that ended April 1. About 700,000 older people who had missed out on their first chance to enroll signed up between October 1, 1967, and April 1 of this year. Now, 18.6 million of the 19.6 million persons 65 and over in the nation are enrolled for medicare voluntary medical insurance.

Social Security Commissioner Robert M. Ball said that the overall social security fund is in good fiscal condition. Medicare received $3.1 billion in fiscal 1967 and disbursed $2.6 billion, Ball said. He said estimates for the next 25 years showed that the program "has a favorable actuarial balance—namely, that total income over the 25 years ahead is expected to exceed total outgo."

Misuse of Federal Programs

Cohen told a House appropriations subcommittee that HEW was very much concerned and was making an intensive investigation of reported abuses by some physicians in Federal medical programs. He said a number of allegations had been made, but that he would not want to make an overall statement until the investigation was completed.

"A typical kind of allegation concerns a doctor who goes into a nursing home—I will be just hypothetical about this—and he is there for an hour and then sends in a bill for an injection of something for every one of 50 people in the institution," Cohen said.

"Then we have had cases of bills being submitted in which the evidence suggests that the volume of services that he is requesting to be paid for is beyond the ability of a particular person to handle. Well, he comes back to that allegation and says, 'I have a nurse and I

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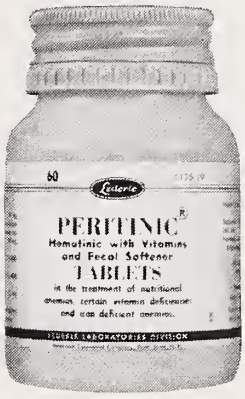

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"The popular criticism usually has to do with the individual fee. I really don't think that is the major issue. The real issue is not so much the fee or the price per unit, but the number of units that the person is saying he delivered."

Cohen said he did not think such practices are widespread but that: "We have enough to be very much concerned about it."

Injunction Against Diapulse Device

A preliminary injunction was issued to halt the sale of a diathermy device distributed by the Diapulse Corporation of America.

The U.S. District Court for the Eastern District of New York, enjoined sales of the Diapulse device, advertised for treatment of 49 diseases and conditions, including tuberculosis, typhoid fever, staph infections, and gangrene.

The diapulse device was seized by FDA in 1965, and found to be misbranded on March 17, 1967, by a Federal court in Hartford, Conn., but the sale of the machine continued pending further appeals.

Safeguards for Children

A group of physicians specializing in child health has endorsed a bill to require special safety containers for drugs, soaps and other household products involved in the poisoning of 500,000 children each year.

The Accidental Poisoning Committee of the American Academy of Pediatrics endorsed the measure sponsored by Chairman Warren G. Magnuson, D.-Wash., of the Senate Commerce Committee. The Academy, in a letter to Magnuson, said the bill was the only "practical way to eliminate hazards from drugs and household products."

1968 CALENDAR OF MEETINGS

August 9-11—International Doctors in Alcoholics Anonymous, Executive Park Motel, Atlanta, Ga.

August 23-24—Medico-Economics Seminar, sponsored by the Atlanta Eye Clinic and the Atlanta Hospital, Atlanta, Ga.

Sept. 13—Georgia Rheumatism Society, Medical College of Georgia, Augusta, Ga.

National

July 21-25—American Veterinary Medical Association, Statler Hotel, Boston, Mass.

July 22-25—Eleventh Annual Ruidoso Summer Clinic, sponsored by the New Mexico Chapter of the American Academy of General Practice, Chaparral Motel, Ruidoso, N.Mex.

August 11-15—National Medical Association, Shamrock-Hilton, Houston, Tex.

August 15-17—Cascade County (Mont.) Medical Society Seminar, Great Falls College, Great Falls, Mont.

August 22-24—Eighth National Cancer Conference, sponsored by the University of Wisconsin School, Division of Clinical Oncology, Park Motor Inn, Madison, Wis.

August 25-30—American Physiological Society (International Congress), Washington, D.C.

August 28-30—Society for the Study of Reproduction, Vanderbilt University, Nashville, Tenn.

Sept. 1-6—Twelfth Congress, International Society of Hematology, Waldorf-Astoria, New York City, N.Y.

Sept. 5-7—American Association of Obstetricians and Gynecologists, The Homestead, Hot Springs, Va.

Sept. 6-7—Ninth Annual Cardiovascular Symposium, sponsored by Tidewater Heart Association and Council on Clinical Cardiology, American Heart Association, Lake Wright Motel, Virginia Beach, Va.

Sept. 13-20—American Academy of General Practice, Las Vegas, Nev.

Sept. 15-20—International Congress on Alcohol and Alcoholism, Shoreham Hotel, Washington, D.C.

Sept. 16-19—American Hospital Association, Chalfonte-Haddon Hall, Atlantic City, N.J.

Sept. 18-20—Sixth National Cancer Conference, Denver Hilton Hotel, Denver, Colo.

Sept. 25-27—American Association of Medical Clinics, The Roosevelt, New Orleans, La.

Sept. 28-Oct. 3—Thirty-third International College of Surgeons, United States Section, Honolulu, Hawaii.

Sept. 30—Society for Pediatric Radiology, Jung Hotel, New Orleans, La.

ANNUAL MEETING SCHEDULED FOR GEORGIA HEART ASSOCIATION

The 20th Annual Meeting and Scientific Sessions of the Georgia Heart Association will be held Sept. 15-17, Sunday through Tuesday, at Callaway Gardens in Pine Mountain, Georgia.

Faculty includes Brian Hoffman, M.D., Michael V Herman, M.D., Thomas D. Reeves, M.D., Augustin Castellanos, Jr., M.D., Victor Parsonnet, M.D., and Albert Heyman, M.D.

Simone Brocato, M.D., will preside over opening sessions, and Thomas D. Johnson, M.D., and C. Dan Cabannis, M.D., over subsequent sessions.

Golf and fishing arrangements will be made.

MEDICAL COLLEGE FOUNDATION ELECTS 1968-69 OFFICERS

Trustees of the Medical College of Georgia Foundation held their Annual Meeting Sunday, May 5, at the Medical College of Georgia Student Center.

The Trustees present were Drs. Irving Victor, Robert T. Anderson, Billy S. Hardman, J. G. McDaniel, Trustee-Elect, Dr. Robert G. Ellison and Dr. Edgar R. Pund, Director. Also present were Dr. Charles G. Green, President of the Alumni Association, Dr. Harry B. O'Rear, president of the Medical College of Georgia, and Mary M. Lewis, Executive Secretary.

The officers for the fiscal year 1968-69 are, Dr. Irving Victor, re-elected president, Dr. J. G. McDaniel, vice-president and Dr. Robert T. Anderson, re-elected secretary-treasurer.

Charles R. Andrews (right) president of the Medical Association of Georgia and Linton H. Bishop, Jr. (left) president of the Fulton County Medical Society present the Hardman cup and a plaque to John Willis Hurst, this year's recipient of the award. Dr. Hurst was honored for his outstanding contributions to the cause of undergraduate and postgraduate education of physicians in Georgia.

MEDIC ALERT MAY SAVE MANY PATIENTS' LIVES

The Medic Alert Foundation, International, is a charitable, nonprofit, tax-exempt organization that provides a medical protection service for persons with any hidden medical problems that should be known in an emergency. Its purpose is to prevent tragic, even fatal mistakes in the course of administering aid to these people.

Doctors, police or others giving first aid are alerted immediately to a person's problems by an identification emblem which is recognized throughout the world. On the reverse side of the emblem is engraved the immediate medical problem of the wearer, for example, "diabetes," "allergic to penicillin," "taking anticoagulants," etc.

Central Filing System

Additional medical information is filed in the Central Answering file in the Turlock, California headquarters. It includes addresses of physicians and nearest relative of every member. The information is available to physicians and other authorized personnel 24 hours a day, via collect telephone call. These services are maintained through a single membership fee, and small service charges for keeping up-to-date records, and through voluntary contributions.

Medic Alert, founded in 1956, is endorsed by the American Academy of General Practice, the American College of Allergists, the American Academy of Allergy, and numerous county and State medical societies.

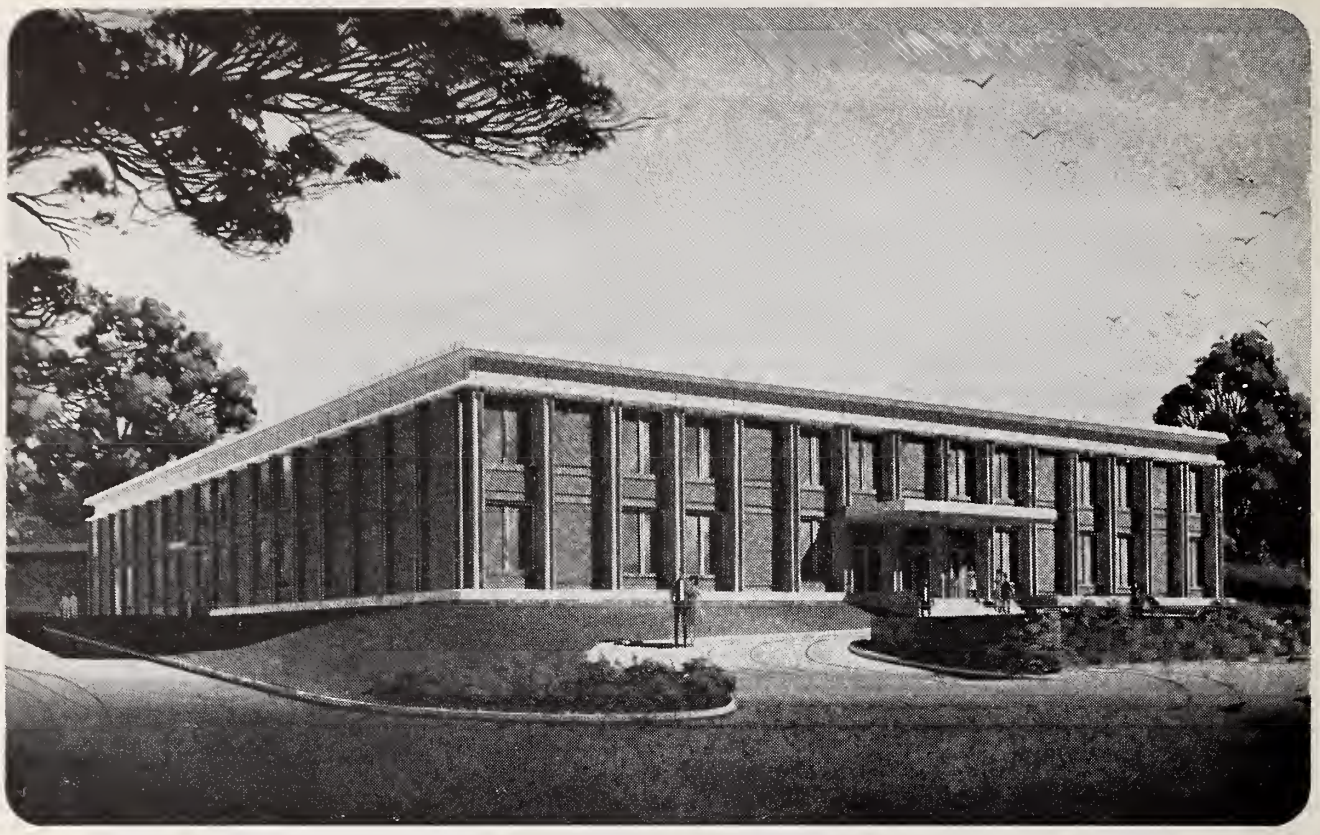
AMA TO SPONSOR ANNUAL SPORTS CONFERENCE

The Tenth National Conference on the Medical Aspects of Sports, sponsored by the American Medical Association under the auspices of its Committee on the Medical Aspects of Sports, will be held in Miami Beach, Florida, at the Hotel Deauville on December 1, 1968. The Conference is held annually in conjunction with and on the first day of the Clinical Convention of the American Medical Association.

As was true of the previous nine conferences, the tenth will cover a wide range of subjects of interest to those serving school and college athletic programs. Included will be forums on the management of knee injuries, back problems, and problems related to vision in sports. Other sessions will be devoted to a series of clinical concerns in sports warranting increased attention (eg, cauliflower ear, pulled muscles, facial injuries, and communicable disease). One discussion session will be devoted to the controversial issues affecting participation of young athletes, another to health and safety considerations in the conduct of aquatic activities.

The featured luncheon speaker will be Payton Jordan, head coach of the 1968 U.S. Olympic Track and Field Team, who will discuss "The Olympics in Retrospect."

The Conference is open to key nonmedical athletic personnel as well as interested physicians. Those who would like to receive further information concerning the Conference should address the Committee on the Medical Aspects of Sports, American Medical Association, 535 North Dearborn Street, Chicago, Illinois 60610.



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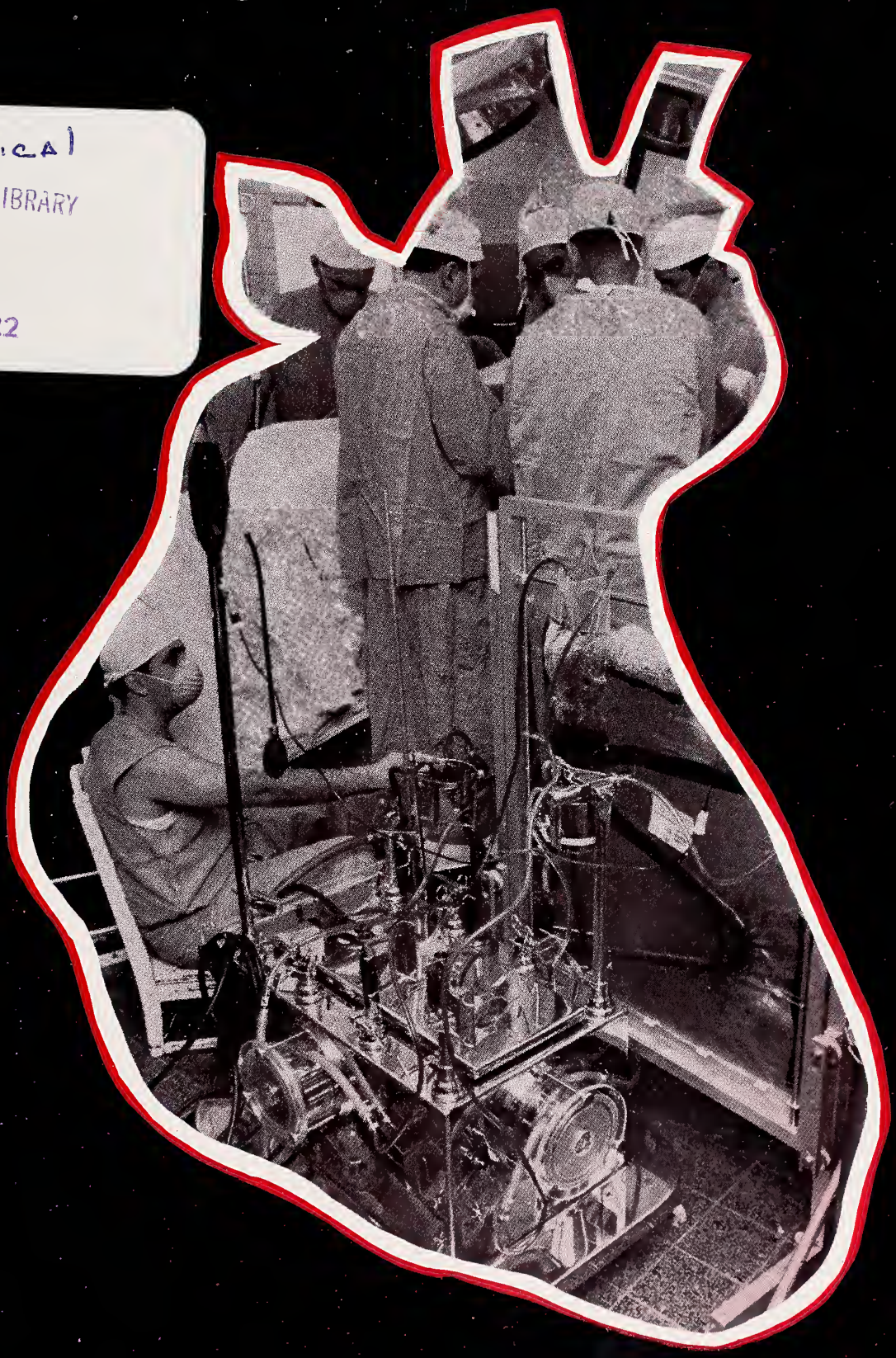

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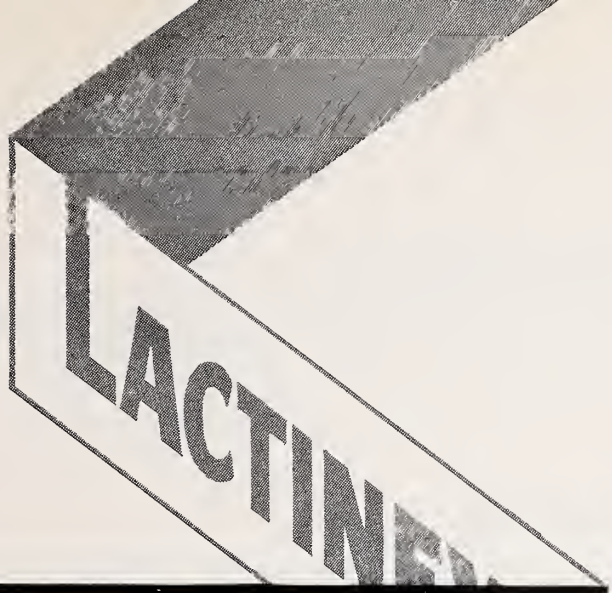

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Photograph by Mr. Joe Jackson; Design by Stein Typography Shop, Atlanta.

JOURNAL OF THE MEDICAL ASSOCIATION Georgia

Many patients at autopsy showed significant central nervous system lesions which had failed to produce symptoms and signs during life.

Some Observations on the Central Nervous System Complications of Chronic Leukemia

DONALD H. McKNEW, JR., M.D., *Columbus*

Involvement of the central nervous system in patients with leukemia has been observed and reported,[1-4] but prior to 1950 and the use of modern chemotherapy, no relationship was successfully demonstrated between central nervous system lesions and the type of leukemia.[1, 2] Recent reports have dealt with the rising rate of occurrence of "meningeal leukemia" in acute leukemia,[5-9] and a possible relationship of white blood cell and platelet levels to the vascular lesions seen in acute leukemia has been suggested.[10-13] This study was undertaken to evaluate the status of central nervous system involvement in chronic leukemia. An effort was made to relate the white blood cell and platelet levels to the cerebrovascular lesions encountered.

Materials and Methods

All the adult patients who died at the Johns Hopkins Hospital with the clinical diagnosis of chronic lymphocytic or chronic myeloid leukemia between the years 1942 and 1960, and whose records had been filed under these diagnoses and were available for study were included in this series. The diagnosis was made on the basis of complete clinical and laboratory studies—serial differential blood counts and bone marrow examinations. Only four cases were eliminated for reason of questionable diagnosis. The time span chosen was a compromise between a desire for a large number of cases and the realization that many diagnostic neurological procedures were done more sparingly in earlier years.

Every case record was studied in detail for any suggestion of neurological involvement. In all cases, the highest white blood count and the lowest platelet count during the course of the illness were recorded, as were the platelet count and white blood count either at the time of death or at the onset of any neurological difficulties. The other usual parameters were also noted—age, sex, race, duration of illness. An attempt was made to correlate clinical with pathological findings at autopsy.

Results

Of the 80 cases studied, there were 46 cases of chronic lymphocytic leukemia and 34 cases of chronic myeloid leukemia. Thirty-six of the 80 cases had complete autopsies performed with thorough examinations of intracranial contents. Table I presents

TABLE I

	Average Age at Death (Years)	Race		Sex		Average Duration of Illness (Years)
		Negro	White	M	F	
Autopsy—lymphocytic	61	7	16	12	11	2.4
Autopsy—myeloid	52	7	6	5	8	2.5
No autopsy—lymphocytic	60	6	12	18	5	3.2
No autopsy—myeloid	48	8	3	4	17	2.5

the general parameters of the entire group, and Table II their white blood cell and platelet counts.

Out of the total group of 80 patients, neurological symptoms and signs were observed in 23 cases. Hemiparesis, hypesthesias, varied nerve palsies, stiff neck, tremors, loss of vision, and convulsions were the most common disabilities. It was observed that many cases with post-mortem investigation showed significant central nervous system lesions which had either failed to produce symptoms and signs or whose signs and symptoms had been overlooked or misinterpreted in the often stormy termination of a leukemic illness. To this end, further analysis was restricted to the 36 patients who received complete post-mortem examinations.

In the group of autopsied cases, 11 were found to have symptoms and signs of central nervous system disease. An additional eight were found to have, at post-mortem, pathological changes in the central nervous system that could be attributed to the leukemic process (Table III). Two patients had insufficient hematological data for analysis.

Two patients with infectious meningitis were seen. One patient (Case 1, Table III) with cryptococcus meningitis had a white blood count of 14,000 and normal platelet count at the onset of the illness, while the other (Case 2, Table III), with pneumococcal meningitis, had a white blood count of 117,000 and a platelet count of 32,000 at the onset of this illness. There were two cases of "leukemic meningitis" (Cases 4, 5, Table III). An additional five patients had an asymptomatic leukemic infiltrate. The average white blood count and platelet count at the onset of the illness or at the time of death was 107,000 and 22,000 respectively.

The ten patients with significant hemorrhagic lesions or cerebral edema were separated statistically on the basis of their white blood counts and platelet counts, and these figures are recorded in Table III (Cases 8, 9, 10, 11, and Cases 12, 13, 14, 15, 16, 17). The probability that this separation is accidental is 5 in 10,000 on the basis of the white blood count and 93 in 10,000 on the basis of the platelet count.

The lesions in the ten cases are noted in Table III. Neurologic symptoms were recorded in seven of these ten cases (noted by asterisk).

The brain weights and their relationship to body length (the most useful correlation in patients who have been chronically ill) were investigated in the above ten patients. The results in the seven cases where data were available are recorded in Table IV.

Drug therapy as well as x-ray therapy was employed in virtually all of these patients. No correlation between type of therapy and course of illness or central nervous system complications was noted.

Discussion

There have been numerous reports over the years concerning central nervous system involvement in leukemia. Several descriptions of the lesions seen and the clinical pictures encountered have been written.[1-4] Most reports prior to 1950 and the advent

TABLE II

	Average of Highest WBC During Disease	Average WBC @ Death or @ Onset of Neuro. Dis.	Average of Lowest Platelet	Average of Platelet Count @ Death or @ Onset of Neuro. Dis.
Autopsy—lymphocytic	124,000	42,000	114,000	75,000
Autopsy—myeloid	301,000	127,000	80,000	60,000
No autopsy—lymphocytic	222,000	150,000	93,000	109,000
No autopsy—myeloid	237,000	104,000	184,000	72,000

of modern chemotherapy noted no significant differences between the complications of acute and chronic, myeloid or lymphocytic leukemia[1, 2] and little attention was paid to etiological concepts. Symptoms occurred in 15-20 per cent of patients in most of the pre-1950 series with hemorrhage causing the majority of the symptoms. Central nervous system involvement was noted in 50-85 per cent of autopsied cases with asymptomatic infiltration causing three-fourths of the lesions.

Since 1950, a number of reports have appeared dealing with "meningeal leukemia," usually occurring in boys with acute lymphocytic leukemia.[5-9] It was noted that meningeal symptoms in this group of patients treated with the newer agents occurred in up to 25 per cent of patients, with lesions occurring in almost all the patients.[5, 6, 9] In 1960, two papers were published bringing together the information about incidence in acute leukemia with some suggestions as to etiological factors.[10, 11] Moore, et al. found that of 117 patients followed, 23 had symptoms of intracranial hemorrhage or subarachnoid hemorrhage, while another 23 had "meningeal leukemia." They correlated the intracranial hemorrhage with high white blood cell count, and subarachnoid hemorrhage with low platelet count, and found that arachnoid infiltration was related to symptomological change in leukemic meningitis. These studies thus highlighted the rise in recent years (presumably related to the advent of chemotherapy) of "meningeal leukemia" in acute leukemia.

More recently, several reports have attempted further to correlate clinical course with the pathological lesions found in both acute and chronic leukemia.[12, 13] Groch, et al., reporting on 235 cases seen at the Mayo Clinic with a variety of leukemic processes, noted 50 per cent of patients, who had full autopsies, to have intracranial hemorrhage. The development of intracerebral lesions following the stasis of cells, vessel wall breakdown, and subsequent outpouring of cells with frank hemorrhage is demonstrated in lesions at progressive stages of evolution. They postulated that the integrity of the vessel wall is the main issue and is affected by multiple factors such as stasis, platelet level, and serotonin.

TABLE III

Case	Age	Sex	White Blood Count @ Onset of Neuro. Disease or at Death 1000's/mm³	Platelets @ Onset of Neuro. Disease or at Death 1000's/mm³	Neurologic Involvement
1	76	M	14,000	normal	Cryptoccal meningitis with small associated subarachnoid hem.
2	55	M	117,000	32,000	Pneumococcal meningitis
3	55	M	600	10,000	Leukemic infiltration of meninges around brain and cord.
4	56	M	17,000	83,000	Perivascular leukemic infiltrate
5	71	F	176,000	22,000	Leukemic infiltrate of arachnoid and dura with small associated subarachnoid hem.
6	63	M	300,000	?	Leukemic infiltrate of meninges around brain.
7	69	F	15,000	84,000	Leukemic infiltration of meninges around hypophasis.
8	51	M	14,000	2,000	Hemorrhage of 5th nerve root extending into pons. Hem. of optic tract.
9	41	F	900	1,000	Hemorrhage in ependyma of lateral ventricles*
10	56	F	2,000	5,000	Subdural hematoma*
11	45	F	600	8,000	Subarachnoid and subdural hemorrhage. Dural, subarachnoid, and perivascular infiltrates.
12	61	F	283,000	134,000	Cerebral pressure cone*
13	32	M	255,000	130,000	Hemorrhage in internal capsule and occipital lobe. Subarachnoid infiltrates.
14	57	F	365,000	162,000	Softening in cerebellum and below lateral ventricles*
15	73	F	361,000	?	Pressure cone in brain stem.
16	40	M	122,000	9,000	Significant cerebral edema*
17	72	F	200,000	12,000	Softening in occipital lobe*

(* Asterisk designates the presence of neurologic symptoms.)

TABLE IV

Cerebellar or Brain Stem Cone			No Pressure Cone		
Case	Brain Weight	Wt./Length	Case	Brain Weight	Wt./Length
12	1,310	8.91	8	1,360	8.34
16	1,550	8.95	11	1,300	7.73
			10	1,100	7.05
			14	1,200	6.74
			17	1,100	6.25

There seems to have been a modest rise in this series as contrasted to pre-1950 series in the incidence of recognized, clinically diagnosed, central nervous system disorders associated with chronic leukemia—27 per cent as compared with 15-20 per cent. The incidence of central nervous system lesions, 50 per cent, is consonant with pre-1950 studies, but is significantly lower than the percentages found in most post-1950 studies on acute leukemia, and, interestingly, the incidence of "meningeal leukemia" in this series is not elevated above pre-1950 levels. Thus, in this series, there has been no spectacular rise in the rate of occurrence of these complications in chronic leukemia as contrasted to the rise seen in the acute form of the disease.

The most interesting aspect of this study comes in the pursuance of the correlation of white blood counts and platelet count levels to neurologic complications. As noted in the National Institutes of Health Study[11] meningeal infiltration and the clinical syndrome, "meningeal leukemia," does not seem to be related to either white blood count or platelet count. However, when the patients with chronic leukemia and central nervous system lesions of either hemorrhagic or edematous origins are separated, using white blood count and platelet count as parameters, they fall into two distinct groups.

The patients who have low white blood counts and platelet counts at death or at the time of the onset of their neurological complications are found at postmortems to have bled from vessels that are intracranial but external to the brain substance. Thus, one might postulate that wherever vessels, subarachnoid, ependymal, subdural, or in cranial nerve roots where they pass from brain to skull, are exposed to trauma or day by day pull and tension as the head is moved, bleeding often may occur when the white blood counts and platelet counts become exceedingly low. This phenomenon is probably related to the platelet level specifically and is typical of the generalized hemorrhagic diathesis in these patients during the terminal phase of their illness.

In contrast, the patients with high white blood counts and normal or more nearly normal platelet levels at death or at the onset of the neurological complications are found to have been afflicted with conditions affecting the brain itself. These intracerebral difficulties are probably related to the high white blood counts and concurrent vascular and clotting mechanism abnormalities which have led to stasis in the small intracerebral vessels and subsequently to thrombosis and hemorrhage, or perhaps to edema without frank areas of softening. The high brain weight to body length ratio noted in two of the patients with cerebral edema (see Table IV) is of interest in relation to the question of high white blood counts being associated with brain swelling without any single lesion being found.

Summary

Central nervous system involvement was reviewed in patients who died of chronic leukemia between the years 1942 and 1960. In 36 patients who received complete autopsies, the incidence of neurological symptoms and lesions was noted and correlated when possible with the hematological parameters. The incidence of central nervous system involvement with respect to both symptoms and lesions was not found to be significantly different from earlier studies. A high correlation between white blood cell and platelet counts and the type of intracranial circulatory disability encountered was found.

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PURISTS WOULD PRESERVE IMAGE

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Purists say that the twin-snake caduceus of Hermes is often erroneously used as the symbol of medicine. They maintain the honor rightly belongs to the single-snake caduceus of Aesculapius. According to *Bulfinch's Mythology*, Hermes was the Greek god of rogues. He was appointed to send the souls of the dead to hell—hardly the best image for physicians. Aesculapius, on the other hand, was the Greek god of medicine and his caduceus represents the life-giving quality of the physician. The single snake, because of its skin-shedding, denotes longevity and immortality.

"MD" CAR BUMPER STICKERS AVAILABLE TO GEORGIA DOCTORS

The green and white, reflective "MD" stickers, which a physician may attach to his car bumper, are once again available from the Medical Association of Georgia. Complete with the seal of the Medical Association and the admonition to "Drive Safely," the stickers may be obtained, free of charge, by writing to: *Medical Association of Georgia, 938 Peachtree St., N.E., Atlanta, Ga. 30309.*

RADIOLOGISTS ELECT NEW OFFICERS

The Georgia Radiological Society, Chapter of the American College of Radiology, elected Harry H. McGee, Jr., of Savannah president for 1968-1969. Also elected at the recent annual meeting of the Society were Mark Brown of Augusta, president-elect; William H. Somers of Macon, vice-president; Walker Harris of The Medical Center in Columbus, secretary; Herschel U. Martin of Dalton, treasurer. Neal F. Yeomans was elected councilor of the ACR, and Donald Rooney of Marietta was chosen as vice-councilor of the ACR. Three members were elected to the Executive Committee. They are I. R. Berger of Athens, W. Eugene Harden of Brunswick, and J. L. Clements, Jr., of Newnan.

Report on the Georgia Regional Medical Program to the MAG Annual Convention—May 6, 1968, Augusta

J. W. CHAMBERS, M.D., *Program Coordinator*

SOME 100 GEORGIA PHYSICIANS and hospital and medical center administrators attended the semi-annual meeting of the Georgia Regional Medical Program's Local Advisory Group Chairmen on March 24 at the Hilton Inn in Atlanta.

Roland Peterson, Planning Branch Chief of the Division of Regional Medical Programs in Washington told the representatives that: "One of the most significant developments in the advancement of Regional Medical Programs—and one in which Georgia in a very real sense led the way—has been the creation of local, community-oriented advisory groups to plan activities designed to meet the needs of their particular local areas and to strengthen relationships between local institutions and the medical centers."

He went on to say that: "Georgia can also take just pride in the fact that its State Medical Association, Public Health Department and two medical schools have taken the initiative in leading the Program's development. It is one of only five regions in which the medical association is serving as the fiscal agent for its program."

The Federal Program

Reporting on progress at the national level, Mr. Peterson said that more than 1,200 organizations are participating in the development of Regional Medical Programs. These include all of the nation's medical schools, many state and local medical societies, state hospital associations, and numerous official and voluntary health agencies, with hospitals making up the largest single group of participating institutions.

Of the nearly 2,000 individuals serving on regional advisory groups throughout the country, practicing physicians comprise 22 per cent, other health professionals eight per cent, medical center officials 16 per cent, hospital administrators 13 per cent, voluntary and official health agency representatives 12 per cent and seven per cent respectively, and interested and informed members of the public 15 per cent—businessmen, labor officials, lawyers, and other community leaders. (Composition of GRMP's Regional Advisory Group shows similar representation percentagewise.)

Planning grants have now been made to 53 regions; 12 have begun operational activities and another 12, including Georgia, have operational grant applications under review. Funds awarded to date for planning grants total over $33 million; and approximately $11.9 million has been awarded for operational grants.

Trends and Developments

Mr. Peterson also related some of the trends and developments that may be in the offing.

1) Monies are, and will be, available through fiscal year 1969 for continued and hopefully increased funding of Georgia's and other regional programs.

2) The request for legislative extension of the program (Public Law 89-239) for a period of five years (through June 30, 1973) has been introduced in both the House and the Senate. (Dr. Chambers recently testified in Washington concerning continued support of the program.)

3) One per cent of Regional Medical Program appropriations is set aside for evaluation (directly or by grants or contracts) of the program.

4) Authority has been requested by the Division of Regional Medical Programs to make grants to any public or non-profit private agency or institution for services needed by, or which will be of substantial use to, any two or more regional medical programs.

5) Authority has also been requested to make grants to combinations of, as well as single, public or non-profit private agencies and institutions to facilitate funding of interregional activities.

6) Expansion of the National Advisory Council from 12 to 16 members has been recommended.

7) Inclusion in the Program of Guam, American Samoa, and the Trust Territories of the Pacific has been proposed.

8) Permission has been requested for dentists as well as physicians to make referrals under the Program and for VA and other Federal hospitals to participate in and receive funds through Regional Programs.

No provision has been made for new construction authority, due partially to budget constraints and the fact that a National Advisory Commission on Health Facilities, headed by Georgia's Boisfeuillet Jones, was recently appointed to look into and make recommendations with respect to the whole area of Federal Assistance for Health Facilities Construction.

Mr. Peterson closed by saying that continued and, indeed, rapid expansion and growth of Regional Medical Programs seems assured.

The Georgia Program

Dr. J. Gordon Barrow, Georgia Regional Medical Program Director, in his review and summary of the Georgia program, said "Our local advisory groups, centered in community hospitals across the State, have served to stimulate a new interest in continuing education and research, in recognizing community health problems, and in measuring the effectiveness of current approaches to disease problems. This concept of local initiative, fundamental to the Regional Medical Programs from the beginning, requires each area to develop its own approach suited to its needs and resources and to affiliate local direction with the overall program of health planning and operation of the Georgia Regional Medical Program."

Grants for Staff Expansion

Continuation Planning Grant funds in the amount of $341,824 and a Supplemental Grant allocation of $213,255 have been awarded to GRMP by the National Institutes of Health for the period from January 1, 1968, to December 31, 1968, to finance the staff expansion necessary to continue planning and to prepare for and develop operational activities.

The staff expansion will include four Program Coordinators who will direct the activities of the Regional Program along with Dr. Gordon Barrow, Director and Dr. Robert Smith, Associate Director.

Field Representatives

Six field people will also cover the various areas of the State and will have a dual responsibility: To act as liaison between the local advisory groups, the community, and the Regional Office, and to assist in planning activities and data gathering in the local areas. Three of these field representatives will be stationed in Atlanta: one to cover the Atlanta Metropolitan area, one to cover North Georgia, and one to cover the central section down to Macon. The other three will be based in Albany, Savannah and Augusta and will cover the respective surrounding areas.

Other staff members already employed are an administrative assistant, fiscal officer, chief field representative, liaison officer, projects officer and communications and information officer. As can be seen, additional office facilities are a must to house a staff of this scope. (Until such time as the MAG's building expansion program is completed) the Program Staff will occupy facilities at Executive Park on the Northeast Freeway in Atlanta, while the administrative staff will remain at MAG headquarters.

The operational grant request submitted March 1 has a budget of slightly less than $2 million for the first 12-month period. The primary review committee at the Division of Regional Medical Programs has met to consider the proposal which will now be submitted to the National Advisory Council and the Surgeon General for approval. Indications now are that these first operational projects in the areas of continuing education and training, related demonstrations of patient care, and research in the delivery of health care services will get underway in Georgia about September 1. A site visit to the Re-

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gional Office by officials from Washington was scheduled for June 6 and 7.

Preparations for Grant Application

In the meantime, the GRMP Staff and task forces are already discussing projects to be submitted in the August 30, 1968 Operational Grant request. Final proposals must reach the GRMP Office prior to June 1, 1968. The task forces will review the proposals and make their recommendations to the Steering Committee in August, after which all proposals will be submitted to the Advisory Group for review and final approval. The official application will be submitted on or about August 30.

Health Careers Council

Another area in which GRMP and MAG are coordinating their efforts along with other allied professional groups is in the organization of the Health Careers Council of Georgia, Inc., the chief purpose of which will be "to stimulate interest in health careers and provide services that will facilitate the entry of qualified persons into health careers in Georgia."

POSTGRADUATE COURSES OFFERED FOR TREATING SPINAL CORD INJURIES

The second of a series of postgraduate medical courses in the care of spinal cord injury patients will be offered to 30 selected physicians in West Roxbury, Mass., October 21-25, the Veterans Administration announced recently.

Experts in spinal cord injury care from VA's specialized centers will lecture and demonstrate treatment techniques on all aspects of the emergency and early care, rehabilitation and continuing care of the spinal cord injury patient.

The course is being conducted without tuition charge to bring the benefits of VA's exceptional experience in this highly specialized field of medicine to the entire medical community.

Applications for attendance may be made to Veterans Administration, Chief of the Spinal Cord Injury Staff, 810 Vermont Ave., NW, Washington, D.C. 20420. Eligibility to attend this course extends to urologists, general surgeons, neurosurgeons, orthopedic surgeons, plastic surgeons, neurologists, and internal medicine specialists.

This bizarre tumor of smooth muscle is often misdiagnosed as a leiomyoma.

Leiomyoblastoma of the Stomach

DOLPH O. ADAMS, M.D., HANS J. PETERS, M.D.,
C. ROBERT MOFFATT, M.D., *and* ROBERT A. PARRISH, M.D.,* *Augusta*

SOFT TISSUE TUMORS of the stomach, constituting 13 per cent of gastric neoplasms, are not uncommon.[11] Tumors arising from smooth muscle account for three-quarters of these and are usually diagnosed with ease. However, Stout has described a bizarre tumor of smooth muscle, the leiomyoblastoma, which is often improperly diagnosed.[12]

Several cases of this entity have been recorded since his original description.[1-6, 8, 9, 13, 14] The following is a report of such a case.

Case Report

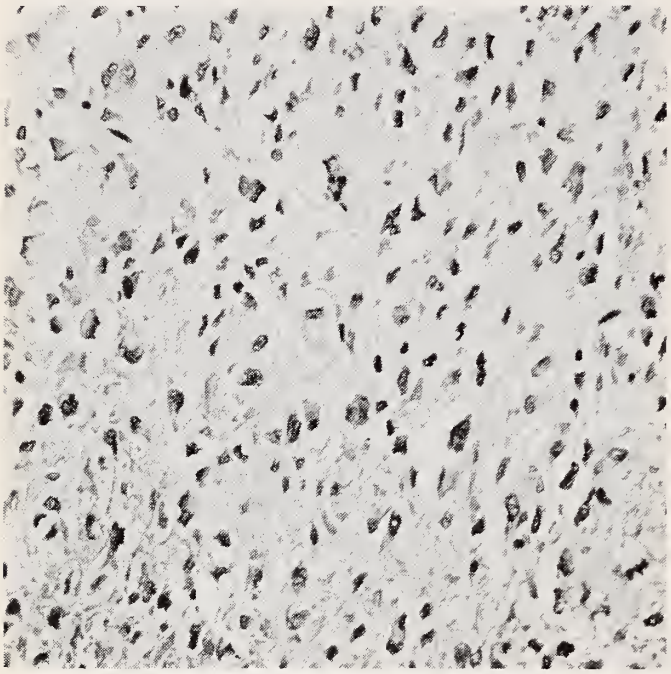
A 64-year-old woman had experienced post-prandial indigestion for many years. Nausea began to accompany the indigestion and she began having occasional tarry stools. Six months later, she entered this hospital.

Pertinent physical findings were enlargement of the heart and an increased blood pressure (150/94 mm. Hg.). The hemoglobin was 12.9 gm. per cent, the hematocrit 39 per cent. The results of a gastric analysis and other laboratory studies were within normal limits. Radiographic examination of the upper gastrointestinal tract revealed a large, pliable, intraluminal mass in the midportion of the stomach (Fig. 1).

Upon laparotomy, a large mass was in the wall of the stomach. No evidence of local or distant spread was noted and a segmental gastrectomy was performed. The post-operative course was uneventful.

Roentgenogram of the stomach filled with barium. A large, soft tissue mass bulges from the lesser curvature into the lumen.

* *From the Departments of Pathology and Surgery, Medical College of Georgia, Eugene Talmadge Memorial Hospital, Augusta, Ga.* *This work was supported in part by the National Institutes of Health, USPHS Graduate Research Training Grant in Pathology, #5T1-GM-207.*



Photomicrograph of a section of the tumor. Plump tumor cells are arranged in a loose, reticular network; clear perinuclear spaces are prominent. (H & E X 260)

The patient has been without symptoms or signs of recurrent tumor for four years.

The resected portion of stomach had a bulky mass on the posterior wall. The disc-like mass bulged into the gastric lumen, arose in the muscularis, and lay entirely between the submucosa and serosa. The mass was neither encapsulated nor well-circumscribed. The cut surface was soft and yellow with interspersed, firm, gray flecks.

Varied Histologic Appearance

The histologic appearance was quite varied. Plump stellate cells, whose cytoplasm was uniformly smooth and eosinophilic, composed most of the tumor. The large nuclei were round and vesicular; mitoses were rare (1 per 50 high-powered fields). The cells stained as muscle with the trichrome stain. The cells took several patterns. Most were in a loose reticulation, where characteristic clear perinuclear spaces which did not stain for glycogen, mucin, or fat were prominent (Fig. 2). In other areas, numerous cells were compactly arranged in solid sheets (Fig. 3), or occasional cells were widely scattered in a hyaline matrix. These three patterns alternated haphazardly.

Throughout the tumor leiomyoblasts, elongated cells which had spindle-shaped nuclei, were seen. Myofibrils were demonstrated by the trichrome and the phosphotungstic-acid-hematoxylin stains. Intermediate forms between these cells and the stellate cells were noted.

The diagnosis of leiomyoblastoma of the stomach was made.

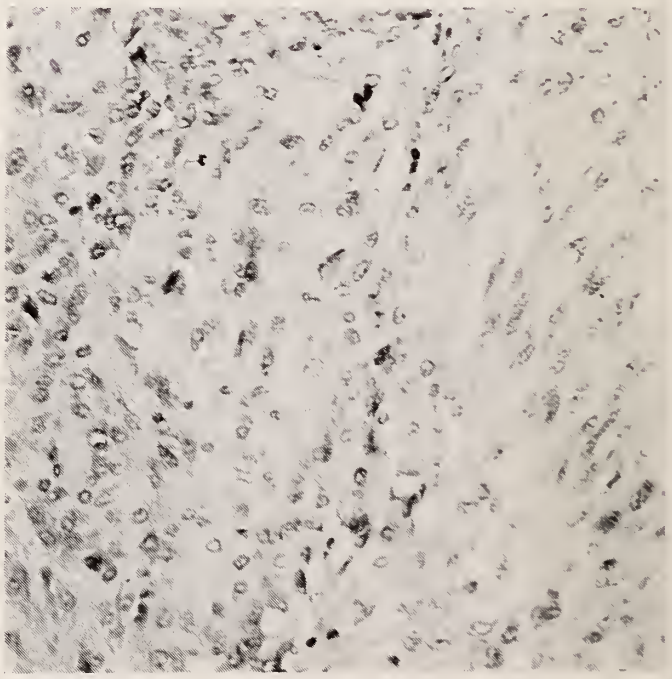
Comment

Bizarre gastric tumors of smooth muscle which bear little resemblance to the usual leiomyoma occur infrequently. Because these tumors are composed of loosely arranged, plump, stellate cells, their histogenesis is rarely recognized. They have been mistaken for tumors of epithelial, fibrous, neural, lipoid, mesenchymal, vascular, and cartilaginous origin. Stout, however, discerned their smooth-muscle origin. He termed these tumors leiomyoblastomas to avoid connoting either uniform benignity or malignancy.[12]

No clinical features distinguish leiomyoblastomas from leiomyomas. Most leiomyoblastomas occur in the fifth, sixth, and seventh decades; two-thirds are in males.[12] Many are found by chance at the operating or autopsy table. If there are symptoms, they are those of patients who have a leiomyoma—pain, anemia, and obstruction.[10] Roentgenologic studies do not separate the two tumors.

Definite Malignant Potential

Although the great majority of leiomyoblastomas are benign, these tumors have a definite malignant potential as evidenced by four reported cases in



Photomicrograph of the tumor. Tumor cells are arranged in a dense sheet at the left; spindle-shaped leiomyoblasts are at the right. (H & E X 260)

which there were metastases.[7, 12, 13] To distinguish such cases is difficult, but tumors which have frequent mitoses are suspect. Apparently, the size, location, and histologic pattern of the tumor are not of prognostic significance.

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ST. JOSEPH'S OBTAINS GRANT TO TRAIN CYTOTECHNOLOGISTS

The Department of Pathology, Saint Joseph's Infirmary, Atlanta, Georgia has been awarded a grant by the Department of Health, Education and Welfare for the training of Cytotechnologists. Dr. John T. Godwin, Director of Laboratories was notified by Senators Richard B. Russell and Herman E. Talmadge and Congressman Fletcher Thompson of the award.

The grant will enable the department to train additionally seriously needed health personnel. Cytotechnologists are in great demand in order to detect early cancer in women.

Through prior grants, the State of Georgia has become the leading State in the nation in performing cancer detection examinations, with 43 per cent of women being examined annually.

Students who have two years of college may be eligible for scholarships to attend a one-year training program at Saint Joseph's Infirmary.

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Results were not as favorable as other authors have reported, but were not as unfavorable as the author feared they might be.

Breast and Cervical Cancer An Audit of a Therapy Practice

HERBERT M. OLNICK, M.D., *Macon*

THIS ACCOUNTING OF RADIOTHERAPY in the environment of clinical practice might be given an alternate title "The Trials and Rewards of Compiling Follow-up Data."

Sources of Information

Information came primarily from the referring doctors' charts or from letters written to the doctors or directly to the patients.

The State Health Department issues a monthly computerized list of cancer deaths with county of residence. Reference to the City Directory helped locate a few. Much of this work was a chore and the employees got pretty bored by the time we got through. When morale declined, I pitched in personally to demonstrate that I thought it was worth the effort. A near disaster occurred when the T-Z death file was lost. T-Z survivors were therefore excluded. The reported series is thus smaller by about 25 per cent than would have been the case otherwise.

The cost of the project was over $2,000 and many months of work. Future evaluations of this kind would be more efficiently accomplished as a part of a larger computerized follow-up system operated by a medical school department or by the State Department of Public Health in which larger series of cases treated by similar methods as a cooperative effort could be gathered.

Incomplete Records

Case summary sheets designed for punch card application were printed. The design was adequate but it's hard to give all the data a number. Many of our therapy charts were deficient. Oncologists had the best case records. Many of the general surgeons had no systematic call back and lost contact with the patient after the active treatment period. The description of the primary lesion often did not clearly indicate the size with clarity. Nevertheless, over-all data were adequate.

Cooperation From Patients' Families

We had some hesitancy in contacting patients directly because the family of the deceased might resent recalling a trying experience. ". . . What has oc-

Presented before the Radiology Section Meeting, 114th Annual Session of the Medical Association of Georgia, Augusta, May 5, 1968.

curred since the treatment and whether there was any further trouble of the kind for which the treatments were given," was the carefully worded inquiry. Surprisingly, most responses reflected appreciation of our interest.

Several patients sent in copies of recent physical examinations and laboratory data. Many expressions of gratitude and encouragement were voiced. The most remarkable was a two page letter from the daughter of a patient who developed pulmonary complications in the lung that had been irradiated following breast surgery. A detailed accounting of the findings on several hospital admissions reported the transition from the diagnosis of radiation pneumonia to tuberculosis and finally, at autopsy, primary lung carcinoma. At the other end of the spectrum was one woman who said she hadn't had a well day since her radiotherapy, although she has remained free of recurrence.

TABLE I

Case Distribution	Cases	NED at 5 years %
Stage I	78	68
Stage II	37	40
Stage III	17	0
Stage IV	12	8

Notes: Stage I—An additional six cases recurred after the five year interval. Recently three cases have had surgery immediately following radiation. All others were treated by radiation alone. Stage II—Early parametrial spread is difficult to be sure of. Several cases with suspicious shortening of a lateral fornix were classified as Stage I. This conservative classification affects one's figures unfavorably.

From 1950-60, 200 KV x-ray was used. Since 1960 a cobalt teletherapy unit has been available.

Stage II carcinoma of the breast treated largely by orthovoltage x-ray following radical mastectomy showed in 48 cases a 5 year survival of 38 per cent, 4 years—40 per cent, 3 years—58 per cent, 2 years—60 per cent, 1 year—81 per cent.

League of Nations Method

Cases of carcinoma of the cervix were classified by the League of Nations method. While the Schmidt classification has the advantage of indicating the size of the local lesion, Schmidt classifications were converted to League of Nations for this report (Table I).

From 1950-59 all radium applications were done by the oncologists. Since 1959 about half have been done by radiologists. Apparent cures since 1959, whether treated by radiologists or oncologists, are equal. However, the radiologists use a fixed type applicator with less rectal exposure, despite larger milligram hours treatment.

The poor results in the advanced cases argue for external radiotherapy as the mainstay in Stages III and IV.

I conclude that the results were not as good as other people claim and not as bad as I had feared.

724 Hemlock St.

GEORGIA HIGHWAY SLAUGHTER

Yearly Totals

1968 to date	773 Killed
1967	1,620 Killed
1966	1,605 Killed
1965	1,354 Killed
1964	1,314 Killed
1963	1,278 Killed
1962	1,106 Killed
1961	1,017 Killed

Through June 1968
773 KILLED

Same Period 1967
794 KILLED

June 1968
98 KILLED

Economic Loss

1968 to date	$148,870,000
1967	307,800,000
1966	288,900,000
1965	243,720,000
1964	236,520,000
1963	230,040,000
1962	199,080,000
1961	162,720,000

Treatment of Psychosomatic Disorders With Bellergal

HENRY E. STEADMAN, M.D., *Atlanta*

Generally favorable results were encountered in the treatment of ninety-seven patients.

"(S)HE IS NEUROTIC" may often be the physician's first impression when confronted with a patient who presents a recital of complaints and symptoms. While this description may be warranted for some, it may disserve many others who are actually beset by a number of annoying and even serious functional disorders. Moreover, this diffident attitude can be self-defeating since it usually negates one prerequisite necessary to effective management of patients presenting with emotional disorders—sympathy.

Multitude of Symptoms

In addition to this sympathy, the patient requires and is fortified by a rapid resolution of the complaints he or she voices. Predominant complaints include gastrointestinal distress, fatigue, insomnia, headache, and palpitations; frequently these are underlaid by nervous tension. For many patients these symptoms and complaints represent a poor response to stress situations with which they cannot cope satisfactorily.

Whatever the cause, patients are seeking rapid relief of their symptoms, and the nature of these suggests a preparation which exerts pharmacological activity at certain end-organ sites, e.g. stomach, head, heart, skin, in addition to providing central sedation. One such agent is Bellergal* which the author has used for a number of years with good effect. In an effort to document these results, the records of 97 patients (91 females, six males) treated with this agent were reviewed. (All patients were taking the sustained-release form, Bellergal Spacetabs, one each morning and each night.)

In general, these patients presented symptoms and complaints characteristic of functional disorders. Many patients also suffered one or more organic diseases or dysfunctions which were not directly related to their functional problems. More than one half of the women (49 of 91) were menopausal; other patients presented with gastrointestinal disorders; and still others were diagnosed as anxiety reactions related to recent surgery, marital problems, etc. The ages of the patients ranged from 25 to 69 years (median, 48 years).

Presenting symptoms were rated as either "mild," "moderate," or "severe," as shown in Table I. The severity of predominant symptoms was recorded before treatment was initiated and was compared with the severity observed at the conclusion of treatment.

* *Sandoz Pharmaceuticals.*

which ranged from two to three months. In addition, an overall estimate of each patient's response to treatment was recorded.

Results

As shown in Table I, the incidence and severity of all target symptoms was markedly altered by Bellergal. The aggregate of all symptoms in the entire patient population before treatment was 585 as compared with 144 after treatment, or a reduction of 75.4 per cent. The reversal in severity is reflected in the pre- and post-treatment incidence; before treatment, symptoms were described as severe in 268 instances, moderate in 245, and mild in 72, while after treatment these were 2, 19, and 123, respectively.

As might be expected, nervous tension or its analogue, anxiety, was the symptom with highest incidence. Running parallel in prevalence and dissipation was insomnia, its alleviation no doubt a reflection of the resolution of other symptoms and obtained without the need for bedtime hypnotics.

Unexpected Benefit

Headache and gastrointestinal distress appeared next in frequency and also responded with a decline in incidence and severity. The reduction in and attenuation of palpitations, hot flashes, and crying spells was equally striking and revealed the usefulness of Bellergal in the treatment of menopausal distress. Elimination of crying spells was an unexpected benefit.

Discussion

The patient who presents a multitude of symptoms often taxes the clinical resources of the physician. Underlying emotional problems, often manifested as "nervousness," involve such patients in a cycle of emotional and physical disorders, one aggravating the other. While sympathetic reassurance is useful as a measure of "practical psychotherapy," it is not adequate by itself to interdict this process. Required, in addition, is prompt resolution of annoying symptoms.

This study has demonstrated the value of Bellergal for symptomatic relief. The effects of this agent are attributed to the integrated actions of its three constituents, bellafoline, ergotamine tartrate, and phenobarbital. Bellafoline primarily affects receptor sites in the gastrointestinal tract, reducing overactivity there and, thereby, relieving "heartburn," indigestion, and nausea. The adrenergic-blocking effect of ergotamine tartrate was primarily reflected in relief of palpitations and hot flashes. These gastrointestinal and vascular effects are complemented by the sedative effect of phenobarbital in ameliorating the concomitant nervous tension. It is interesting to note here the practical value of the sustained-release form of Bellergal: One Spacetab given twice daily was adequate to obtain the effects described here.

Useful for Menopausal Patient

As in other studies,[1, 2] Bellergal was especially useful in treating the emotional disorders associated with the menopause. This was evident even in those cases where estrogens were indicated and used. Relief of somatic complaints resulted in easing of nervous tension and a general sense of well-being. It was also of benefit in patients whose complaints were associated with diverticulitis, gastritis, duodenal ulcer, and/or colitis. This was in line with Waller's[3] observations of attenuation of indigestion and epi-

TABLE I
SEVERITY AND INCIDENCE OF TARGET SYMPTOMS

	Number of Patients With Symptoms							
	Before Treatment				After Treatment			
Symptoms	Total	Mild	Moderate	Severe	Total	Mild	Moderate	Severe
Nervous tension	88	7	48	33	23	20	3	0
Insomnia	88	3	29	56	29	27	1	1
Anxiety	87	5	22	60	20	15	5	0
Headache	82	5	36	41	24	21	3	0
Gastrointestinal distress	64	10	27	27	23	18	4	1
Palpitations	47	12	27	8	13	12	1	0
Hot flashes	44	4	7	33	5	4	1	0
Crying spells	16	3	11	2	0	0	0	0
Tremors	34	11	22	1	8	7	1	0
Restlessness	25	10	10	5	2	2	0	0
Dizziness	10	2	6	2	1	1	0	0
Incidence of all symptoms	585	72	245	268	144	123	19	2

gastric pain. Similarly, the ability of Bellergal to lessen the severity and frequency of recurrent headaches[4, 5] was also observed in our patients where headache was a predominant complaint. As a result of treatment, the incidence of moderate or severe attacks remitted almost completely.

Mild Side Effects

The favorable results of treatment with Bellergal were secured with only occasional and mild side effects (i.e. drowsiness, dryness of the nose or mouth, blurred vision). These effects are characteristic of an anticholinergic (bellafoline) and were corrected readily by dosage adjustment.

Summary

Functional complaints associated with emotional imbalance were treated with Bellergal Spacetabs for periods of two to three months. Substantial reduction in severity and incidence of target symptoms, notably nervous tension, insomnia, headaches, and gastrointestinal distress, was obtained. Side effects were mild and infrequent.

340 Boulevard, N.E.

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AMA PREPARES GUIDE TO AID IN DRIVER LICENSING

The Wisconsin Medical Journal

A new attack has been launched on the problem of providing a more adequate method of determining the fitness of applicants for driver's licenses. The spearhead of the attack is a new guide, "Determination of Need for Medical Evaluation in Driver Licensing," just developed by the AMA Committee on Medical Aspects of Automotive Safety.

Suggests Screening Procedure

This guide, aimed at non-medical licensing authorities, suggests a screening procedure to be used on all license applicants, with only those seeming to present an unwarranted risk as drivers being required to have an examination by a physician. To do such screening effectively, lay licensing authorities will have to have medical advice and guidance. The Committee on Medical Aspects of Automotive Safety suggests that state medical association committees on automotive safety work very closely with state licensing authorities and also with county medical societies.

In addition to improving licensing procedures, the AMA Committee feels that this new guide will go a long way toward eliminating agitation for legislation which would require medical examinations for all drivers, as well as that which proposes compulsory reporting by physicians of conditions in their patients which might make driving unsafe. Both of these principles have been opposed by the medical profession for many reasons, principally that they are unworkable. In addition, the compulsory reporting proposal is felt to interfere with the confidentiality of medical records as well as with the traditional physician-patient relationship.

"Determination of Need for Medical Evaluation in Driver Licensing" was published originally in the March 4 issue of *The Journal of the American Medical Association*, and reprints were distributed April 5 to state medical associations. Individual copies may be obtained from the Committee on Medical Aspects of Automotive Safety, American Medical Association, 535 North Dearborn Street, Chicago, Ill. 60610.

HIGHLIGHTS OF EXECUTIVE COMMITTEE OF COUNCIL MEETING, JULY 14, 1968

This summary is being printed so that MAG Officers and Councilors may be advised of the actions of the Executive Committee between meetings of Council. It covers only major actions and is not intended as a detailed report in lieu of meeting minutes.

Headquarters Building Expansion—After a progress report by Dr. J. G. McDaniel, Chairman of the Headquarters Building Expansion Committee, and Edwin F. Smith, Executive Secretary, on negotiations with regard to the securing of construction and permanent loan with the result that a commitment was obtained from the Decatur Federal Savings and Loan Association, a motion was passed that $40,000 be transferred from the American Bank of Atlanta, Atlanta Federal Savings, and the Standard Federal Savings to the Decatur Federal Savings and Loan to form a basis for future borrowing for construction purposes. In a related action, the Executive Committee approved the rental of sufficient parking spaces adjacent to the Headquarter's property for the entire staff during construction. Finally, with relation to the Headquarters Expansion project, the Executive Committee expressed its commendation to all who aided in obtaining the loan for building expansion.

Title XIX—After reviewing the recommendations from the Title XIX Committee which included a recommendation that MAG submit a bid for a contract with the Department of Public Health to perform the duties of certifying the usual and customary fees, and reviewing for utilization all Medicaid claims, the Executive Committee determined that a bid would be submitted prior to the deadline of July 25, 1968. After a very lengthy discussion, the Executive Committee voted to approve inclusion in the bid a cost figure which would accommodate the employment of a physician for half time at a salary of $18,000 per year.

Printing the Constitution and Bylaws—After receiving reports on the costs of insertion of the Constitution and Bylaws in the Roster, and hearing suggestions for producing the Constitution and Bylaws in other forms, the Executive Committee instructed the Editor and Executive Secretary to continue their investigation of this matter. In a connected action, the Editor was asked to consider a mid-year supplement to the JOURNAL in addition to the annual Roster distributed in January, and also asked that a report on this matter be given to the September Council meeting.

Georgia Regional Medical Program—Dr. J. Gordon Barrow, Director of the Georgia Regional Medical Program, announced that the United States Public Health Service had approved an operational grant in the amount of $1,416,777.00, and discussed the distribution of these funds.

Employee Benefits—After reviewing the situation of new MAG employees, who wish to have tax free payments of annuity insurance withheld from their salaries, the Committee voted its approval of the principle of payroll deductions for this purpose and stated that it would be approved for all employees.

Committee Conclave—President Andrews announced the dates of September 7-8, 1968, for the First MAG Committee Conclave to be held at the Atlanta Marriott Motor Hotel, and discussed the program format.

Other Actions of the Committee were as follows:

—One hundred dollars was voted from the Executive Committee's discretionary fund upon request from the Insurance and Economics Committee to meet the statement submitted by Mr. John Glenn, Consultant Actuary to the Committee.

—Voted to recommend to the Council that an appropriation of $200 be approved for the new Professional Conduct and Medical Ethics Committee, so that the new Chairman might attend the AMA National Congress on Medical Ethics in Chicago, October 1968.

—Approved payment from the Executive Committee's discretionary fund of $75.00 for meeting room rental during the Committee Conclave, September 7-8.

—Appointed Dr. Milford Hatcher, of Macon, Chairman of the Historical Committee and Dr. Irving Greenberg, of Atlanta, Chairman of the Medicine and Religion Committee.

—Heard a report from President Charles R. Andrews, Jr. on recent meetings held with Liaison Committee on the Georgia Osteopathic Medical Association to discuss the possible establishment of a joint Board of Examiners. Recent discussions between the two groups have produced concrete steps toward this ultimate goal including preliminary decisions regarding the format for osteopathic refresher courses to be conducted at Emory University and the University of Georgia Medical School.

—Heard a report from the Executive Secretary on the continuing progress being made by the Hospital Activities Committee in its efforts to assist the physicians in Hart County in their relationship with the Hospital and Hart County Board of Finance.

—Noted that MAG's resolution requesting changes in the Emory-Grady agreement has been acknowledged as received by Dr. Arthur P. Richardson, Dean of Emory University Medical School.

—Received a report from the Executive Secretary on progress being made toward the development of materials and time schedule for central billing of all dues in those counties requesting that they be included in this project.

—Received a report by the Executive Secretary that the Georgia Department of Public Health request for a five year grant to study standards for laboratory procedures in physicians' offices had been withdrawn.

—Requested Dr. Haverty to discuss the application of MAG employee work rules with respect to the government programs with the Directors of the respective programs and report back to the Executive Committee on his discussions at the August meeting.

COMMITTEE CONCLAVE

THE CONCEPT OF THE Medical Association of Georgia conclave of committees is another effort to strengthen and improve the operational effectiveness of our organization. As you know, committees are suggested by the Executive Committee and approved or changed by the administrative Council. In the past, many committees have existed in name only. This is a delay and drag on the purposes and requirements which should be the main efforts you ask of your MAG for efficient operation.

A meeting of all committees of the MAG has been scheduled for September 7-8, 1968, at the Marriott Motor Hotel in Atlanta. As soon as a schedule of meeting times can be developed by our executive staff, each association committee chairman and committee member will be informed of the time and date of his respective committees and room set aside for that committee. Hotel reservation forms for those wishing to bring their families and enjoy the facilities of the Marriott this weekend will be enclosed with the committee meeting notices.

It is important that our committees act not only with intra-relationships but with inter-relationships. The closer knit our activities become, the more effective our operation will be. Those association members having committee responsibilities should hold themselves available, as far as possible, on September 7-8.

This initial meeting of all State Association Committees, scheduled to be held one-third into the fiscal year, is designed to bring coordination to the work of the committees. This will undoubtedly lessen somewhat the details of arrangements and the actual conduct of committee work when many of these committee meetings

are scattered over the entire association year. This schedule will also allow approximately two-thirds of the year remaining for the implementation of any plans made by the committee at this initial meeting.

THE AIR FORCE AND PUBLIC RELATIONS

REPRESENTING THE Medical Association of Georgia, it was my privilege to have been invited on a tour of the Air Force Academy and the American Defense Command along with a group of other professional and businessmen from this Southeastern area. The trip was most enjoyable and quite educational. Being Georgia bred, raised and acclimated, it was only natural that some sour grapes stuck in my craw when the Air Force Academy was established in Colorado instead of Georgia. However, after seeing the setting, it is readily understood why this site was selected. The installation is almost beyond comprehension, and once one has seen it, it is still hard to believe.

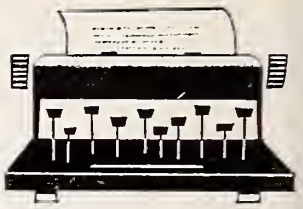
This trip indeed was an outstanding public relations venture on the part of the Air Force. It was most gratifying to observe these dedicated men who are in charge of the development of a section of our future citizens, and protectors of our nation and way of life.

So far, our military academies are not socialistically inclined and we can take many lessons from their way of life. The stronger the Medical Association of Georgia becomes, the more effective we can be in striving to maintain our free enterprise system of the practice of medicine, and the better we can follow in the footsteps of some of our wiser Forefathers.

Charles R. Andrews Jr M.D.

Charles R. Andrews, Jr., M.D.
President, Medical Association of Georgia

EDITORIALS



Chairmen's Conference

THE YEAR 1968 WILL SEE ANOTHER "FIRST" in MAG's Chairmen's Conference. Leading off the Committee Conclave on September 7-8, 1968, will be a conference of all MAG Committee Chairmen, called by MAG President Charles R. Andrews, Jr., M.D. The purpose of the Chairmen's Conference is to set the tone, explain the ground rules and objectives, and issue the challenge of the Conclave.

Scheduled for 9:00-9:45 a.m., September 7, the Chairmen's Conference will signal the beginning of renewed interest and participation in MAG Committee activity.

Congratulations,

Georgia State College

JOHN RHODES HAVERTY

THE ANNOUNCEMENT by Georgia State College of the selection of Dr. John Rhodes Haverty of Atlanta as Dean of the new School of Allied Health Sciences can only bring credit to the selection committee of the Georgia State College Board. The Medical Association of Georgia congratulates them on their foresight and desire to capitalize on the many talents of our Secretary, and at the same time says: "Welcome, Dean Haverty."

Cardiac Transplantation

THE NEWS FROM GROOTE SCHUUR HOSPITAL, Capetown, South Africa, of Professor Christiaan Barnard's initial cardiac transplantation upon patient Louis Washkansky, elicited an unparalleled response from the general public and the medical profession. The response was, in the main, quite favorable, ranging from enthusiastic acclaim, hailing the procedure as "the ultimate operation," to moderate criticism tempered with admiration for the young American-trained surgeon's technical ability and professional audacity.

Not Ideal Recipient

As the medical evidence came in, it was soon apparent that Louis Washkansky was not an ideal transplant recipient, having in addition to the extensive myocardial fibrosis and ventricular aneurysm which necessitated the cardiac replacement, long standing diabetes mellitus and an ulceration of the lower extremity from which pseudomonas aeruginosa had been obtained in recent culture. In addition, tissue typing techniques revealed that one definite incompatibility and one doubtful incompatibility had existed in major antigen types between the recipient Washkansky and his donor, a young female trauma victim. Selection of Washkansky as the pioneer recipient for cardiac transplantation was based on his remarkable traits of character and the terminal status of his cardiac disease. According to his South African physicians, Washkansky, familiar with the local research activity in the field of cardiac transplantation, earnestly desired the procedure and they felt incapable of denying him this opportunity to live. The procedure was an unqualified technical success with the patient's hemodynamics returning promptly to normal and no significant surgical complications encountered. Justifiable concern regarding the threat of rejection resulted in apparent over-treatment with immunosuppressive agents. Bilateral bronchopneumonia developed, which was originally interpreted as a rejection phenomena since sputum cultures were negative, and in spite of heroic therapy, death occurred approximately two weeks after transplantation.

American Efforts

With this effort, Christiaan Barnard set in motion pressures which could not be denied. Within a short period of time, cardiac transplantation was attempted un-

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From the Joseph B. Whitehead Department of Surgery, Division of Thoracic and Cardiovascular Surgery, Emory University School of Medicine, Atlanta, Georgia.

successfully in this country by Dr. Norman Shumway of Stanford University and Dr. Adrian Kantrowitz of Maimonides Hospital, Brooklyn, New York. Both of these workers have been unjustifiably criticized for the unfortunate timing of their efforts, but in reality, both had worked extensively in the laboratory on cardiac transplantation and were planning human cardiac transplantations well before Barnard's initial procedure. In fact, Shumway had developed a surgical technique generally employed for cardiac transplantation (preservation of atrial cuffs in lieu of anastomosis to the vena cavae and pulmonary veins) and Kantrowitz, feeling that implantable mechanical hearts would become feasible for adults, had conducted extensive laboratory investigation of cardiac transplantation in puppies, leading to his initial attempt at human transplantation in a newborn infant with incurable congenital heart disease.

To this writing, 24 cardiac allographs have been performed throughout the world. Seven heart transplantation patients are alive at the moment—three in the United States and one each in South Africa, France, Canada, and Chile. The largest experience with human cardiac transplantation has been developed at St. Luke's Episcopal Hospital in Houston, Texas by the surgical team of Drs. Denton Cooley, Robert Bloodwell, and Grady Hallman. The longest survivor has been obtained by Barnard in his second transplantation in South Africa. This patient, Philip Blaiberg, received the heart of a colored man, Clive Haupt, age twenty-four, on January 2, 1968, and is the only transplantation patient to be discharged from the hospital and thereby derive obvious benefit from the procedure.

Obviously, the hope offered by cardiac transplantation requires exploration, but is the expectation of success sufficient to justify the tremendous effort, expense, morbidity, and mortality presently associated with the procedure? Many have asked why American cardiac surgeons, possessed of the technical ability and facilities necessary, left the pioneer efforts in the field to a young South African. This question cannot be completely answered, of course. Most cardiovascular surgeons in this country preferred to use the kidney as transplantation prototype for obvious reasons—the increased availability of a paired organ and transplantation of an organ which if rejected did not necessarily result in death of the recipient. With renal transplantation as a basis for study, it was hoped that improved techniques in tissue typing and immunosuppression could be evolved and that in proper time, and in certain medical centers, transplantation techniques could be extended to other organs such as liver, heart, and lungs.

American Position Re-examined

As the survival of cardiac transplantation recipient Blaiberg stretched into months, it became necessary to re-examine the American position on cardiac transplantation. To assess the status of cardiac transplantation, the National Research Council called a conference in Washington, D.C. in May, 1968 and the Regents of the American College of Surgeons have appointed a select committee with Professor C. Rollins Hanlon of St. Louis as chairman to assess all data and experience available on cardiac transplantation to date, and to present recommendations and conclusions to be presented to the College and to the entire medical community.

If moral, ethical, religious, and legal questions are excluded, and cardiac trans-

plantation as a medical problem is discussed in the light of the current "State of the Art" certain points are worthy of emphasis.

Criteria for Transplant Patient

Etiological indications for cardiac transplantation include myocardiopathies, coronary heart disease, congenital heart disease, and primary malignant tumors of the heart. The proper candidate for cardiac allograph should satisfy the following criteria: (1) the patient strongly desires the procedure; (2) myocardial disease is diffuse; (3) medical and surgical treatment have been exhausted; (4) death is imminent; (5) lungs, liver and kidneys are salvageable; (6) there is an absence of associated diseases such as diabetes mellitus, infection (especially fungal) and tuberculosis; (7) the patient is emotionally stable and of moderate intelligence; (8) there is satisfactory immunological compatibility with the donor; and (9) indications for transplantation have been agreed upon by two cardiologists, a cardiac surgeon, and an immunologist.

Best Surgical Techniques

With such a patient, and if a suitable donor is available, cardiac transplantation may be offered on the basis of clinical experimentation. The best results have been obtained with the following surgical techniques: (1) exposure is obtained through a median sternotomy; (2) large cuffs of both atria are left in position; (3) anastomoses are performed with continuous suture; (4) the sequence for anastomosis is left atrium, septum, right atrium, pulmonary artery, and aorta; (5) electrical defibrillation may or may not be required; (6) silhouette markings are employed to permit postoperative evaluation of cardiac size; (7) an epicardial electrode is positioned to permit the more precise measurement of the height of the R wave in lead 2 as a means of diagnosing rejection; and (8) the pericardium is left open to avoid cardiac tamponade.

One of the earliest concerns regarding cardiac transplantation was related to total denervation and its effect on cardiac rhythm and function. Experience has shown that denervation is not incompatible with satisfactory function. The nervous regulation is replaced early by humeral mechanisms. Renervation is enhanced by leaving large atrial cuffs about the major veins to preserve nerves. Fortunately, regeneration occurs in three to five months, and this is associated with significant improvement in cardiac output. The rate of a denervated heart will vary with metabolic demand, but adjustments in rate require a longer period of time.

Cardiac transplantation is obviously facilitated if pronouncement of death is based upon documentation or irreversible neurological damage and the heart removed prior to cessation of cardiac activity. For the many who wish to avoid the responsibility inherent in such a decision, pronouncement of death may be based on cessation of cardiac activity with the use of hypothermia, prompt institution of cardiopulmonary bypass, isolated cardiac perfusion, and metabolic inhibition with drugs employed to preserve the donor heart until transplantation is achieved.

Postoperative Treatment

Postoperatively, cardiac transplantation patients are placed in protective isolation, covered by methacillin routinely and other antibiotics as indicated, given cardiac drugs in the usual dosage, and maintained on immunosuppressive agents. All transplantation patients to date have received steroids and Immuran, and the most recent patients have also received antilymphocyte serum or antilymphocyte globulin. It is anticipated that antilymphocyte serum of acceptable quality will become commercially available by the end of this year. For the present, immunosuppression appears to be a more obtainable solution to rejection than techniques

of tissue typing. Any major effort in cardiac transplantation should await the availability of antilymphocyte serum.

Rejection Is Difficult to Diagnose

It has been established that cardiac transplantation is feasible from the technical standpoint and that the transplanted heart can function satisfactorily. The threat of rejection is constant and requires indefinite immunosuppression and careful management of even minor episodes of infection. The diagnosis of rejection of cardiac transplants is not always easy. The clinical signs are of little value. Enzymes are of no value. Rejection is suspected in a transplant patient who manifests lethargy, weakness, and weight loss, particularly so if these symptoms or signs are associated with an increase in heart size. The evaluation of cardiac size is particularly difficult following transplantation since in general a very large heart is replaced by a much smaller organ. The extra space within the pericardium tends to fill rapidly with fluid and if the pericardium is closed, tamponade may develop, as was the case with Barnard's second heart transplant, Philip Blaiberg, who required pericardiocentesis on multiple occasions.

It is therefore desirable to leave the pericardium open and also to place clips along the cardiac borders at surgery so that accurate determination of heart size can be made on postoperative roentgen examinations of the chest. To many, the best means of diagnosing rejection has been the development of decreased amplitude of the R wave in lead 2 and to avoid misinterpretation resulting from pericardial fluid, it is advisable to leave in an epicardial lead for this particular study.

Summary

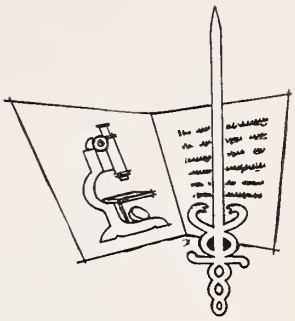
In summary, it would seem that there are patients who would benefit from cardiac transplantation and no other available technique. Cardiac transplantation is technically feasible. Rejection is inevitable if not ablated by effective immunosuppression, and the diagnosis of cardiac rejection is often difficult to make until it is too late to successfully modify immunosuppressive therapy.

The survival of cardiac transplantations has not been sufficiently frequent or long term to justify optimism at this time. It is desirable to continue cardiac transplantation on a limited basis under carefully controlled conditions. Without additional experience, the existing problems cannot be solved and an ultimately successful technique evolved.

Ideally this experience should be obtained in one center adequately financed by the National Heart Institute and staffed by proper professional personnel from throughout the world. A number of the professional personnel could be rotated on a staggered basis to permit wider participation and permit other centers to keep abreast of developments. Such a project might avoid duplication of failures and to permit research of undeniable public interest to be performed in a proper atmosphere. It seems unlikely that such an approach to the problem will be undertaken. It therefore seems inevitable that cardiac transplantation will proceed on a sporadic and haphazard basis, and that in time, successful results will be obtained, based on improved tissue typing, improved immunosuppression techniques, and increased ability to recognize rejection.

Charles R. Hatcher, Jr., M.D.

CANCER PAGE



HOW TO SAVE A MILLION

DALE E. DOMINY, M.D., ***Atlanta****

ALL MANNERS of medical efforts, with energies directed toward eliminating diseases, from muscular dystrophy to congenital diseases of the unborn are a part of our daily lives. As physicians many of us are concerned in one way or another with all of these.

Today we have a rare opportunity to give life at once . . . with no more effort than the spoken word . . . as the result of positive proof: "DO NOT SMOKE CIGARETTES."

Progress has been made through various stages of education concerning tobacco and cancer. First we had clinical impressions, next proven relationship, and now, finally, proven etiology for 95 per cent of the lung cancers . . . CIGARETTES.

What remains are no aphorisms, no platitudes, but direct action toward informing the public about a disease they cannot afford . . . they cannot even afford to get it.

As doctors, we should be reminded of certain statistics. The American Public Health Service has estimated that 1,000,000 high school students now in school will someday die of lung cancer . . . *IF* they continue their present tobacco smoking habits.

From *Science* (22 Dec., 1967, Vol. 158, No. 3808) we have a recital of the various polluting agents in tobacco smoke. If one were to follow a bus on the Atlanta Expressway, he could inhale 120 parts per million of carbon monoxide.

If one inhales the smoke from the average cigarette, he inhales 42,000 parts per million of carbon monoxide gas, which means if the smoker did not sometime inhale fresh air, he could die of carbon monoxide poisoning eventually. In addition, there is nitrogen dioxide, a known pulmonary irritant in industry, and hydrogen

* *Dr. Dominy is Chief of Thoracic Surgery, Atlanta Veterans Administration Hospital.*

cyanide. Ten parts per million of the latter is considered dangerous . . . and there are 1,600 parts per million in cigarette smoke. Other hazardous agents found in tobacco smoke include acrolein, aldehydes, phenols and carcinogens such as benzo(a)pyrene. Evidence points to synergistic effects among the toxic agents. The phenols, though not in themselves notably carcinogenic, increase markedly the carcinogenic potency of benzo(a)pyrene.

The conclusion of the article in *Science* concerning the toxic agents was that these agents would give reason to actively discourage smoking. No one knows what per cent of the 12 per 100,000 non-smokers who develop lung cancer actually get cancer from inhaling smoke from other people.

The underlying hope of the American Cancer Society is: (1) Early signs and (2) Hope for cure. . . .

Unfortunately, in the case of lung cancer there usually is no early sign, and the cure rate of detected pulmonary cancer is from two to five per cent. The total adverse effect of the consumption of tobacco products on our society, if we consider chronic lung disease and heart trouble, probably exceeds the accumulated adverse affect of bubonic plague on previous generations!

I am reminded of a quote from Patrick Henry's famous addres: "Why stand we here idle. . . ."

CONGRESS ON DISEASES OF THE CHEST

IS SCHEDULED FOR OCTOBER

The Tenth International Congress on Diseases of the Chest, sponsored by the Council on International Affairs of the American College of Chest Physicians will be held at the Washington Hilton Hotel, Washington, D.C. October 4-8. One hundred forty-four scientific papers on all aspects of cardiovascular and pulmonary diseases will be presented.

The scientific program will include round table luncheon discussions, medical motion pictures, Fireside Conferences (informal discussions), the Second International Conference on Medical Education, scientific and technical exhibits, and the First International Physicians Art Exhibit.

For further information and registration forms, write the American College of Chest Physicians, 112 East Chestnut Street, Chicago, Illinois 60611.

ELECTROCARDIOGRAPHIC INTERPRETATION IN THE PRESENCE OF PULMONARY DISEASE

Nancy C. Flowers, M.D. and Leo G. Horan, M.D., ***Augusta***

THE ELECTROCARDIOGRAPHIC FINDINGS associated with pulmonary disease fall into the categories shown in Table I. Particular care should be taken to distinguish (1) electrocardiographic changes due to the altered state of the lung alone from (2) electrocardiographic findings which are truly indications of heart disease secondary to lung disease. The former arise from changes in the immediate extracardiac environment which modify the cardiac signal on its way to the body surface. The latter result from intrinsic cardiac alterations in response to excessive loading of the right heart.

TABLE I

Changes in Thoracic Volume Conductor
- **Low voltage in limb leads, V_5-V_6**
- **Small r, deep S in V_{1-4}**

Right Atrial Loading
- **P pulmonale (II, V_1)**
- **T_a effect on ST (lateral "S")**
- **QV_{1-3}**

Right Ventricular Loading
- **Right axis deviation; prominent R in aV_r**
- **Drop in precordial R/S ratio**
- **Late R or R′ in V_1; prominent S in V_6**
- **Right bundle branch block (RBBB)**
- **Q_3T_3**
- **Elevated ST; inverted T in V_{1-3}, aV_r**

Rhythm Disturbances
- **From drugs**
- **From electrolyte imbalance**
- **From pulmonary embolism**

Prepared at the request of the Committee on Professional Education of the Georgia Heart Association.

Manifestations of Altered Intrathoracic Conductivity

The finding of a small r-large S pattern in leads V_1-V_4 with a +90° QRS axis and a small voltage in V_6 is frequent in patients with significant chronic pulmonary emphysema. It is convenient to think of this pattern resulting from depression of the diaphragms and lowering of the heart so that a rightward axis shift occurs and the precordial ventricular complexes take the rS form because they are "looking" down into the lowered ventricular cavity.

Increased Right Atrial Loading

In the presence of right atrial enlargement, the size of the activation wave in the enlarged right atrium is larger than normal and therefore contributes more than normal voltage to the P wave. Enlargement of the right atrium thus accounts for the tall (2.5 mm or greater) P wave of normal duration in leads II, III, and aV_f—called "P pulmonale." In congenital heart disease the abnormally tall P wave usually has an axis of about +60°. By contrast, in chronic lung disease the frontal plane axis of the similarly abnormal P wave is usually nearer +90°. The enhanced insulating effect of the emphysematous lung, plus stretching of the atrium along its vertical axis by sustained depression of the diaphragm may account for the greater right axis deviation of the P wave.

P-wave enlargement is frequently accompanied by greater prominence of the atrial recovery wave (T_a) which distorts the ST segment so that it appears depressed. This may be distinguished from true ST depression by noting that the PR segment slants down and the ST segment slants up. The QRS thus appears to be sitting in the hollow of a shallow bowl. Clinicians have long inferred the presence of emphysema from the PR-ST-T which looks like "an S lying on its side."

Manifestations of Excessive Loading of the Right Heart

If the contributions of the two ventricles to the QRS complex of V_1 are considered separately, the left ventricle alone (including the interventricular septum) may be considered to yield an rS configuration very similar to the normal pattern but with small r and deep S. The difference between the theoretical contribution of the left ventricle and the actual configuration found in V_1 then is equal to the contribution of the normal right ventricle, a small qR complex. Enlargement of the right ventricle with consequent accentuation of its contribution may be expected to deform progressively the V_1 QRS pattern from normal to an rS pattern with shallowed, notched S an rSr′ pattern and even finally to an rsR′ pattern. In practical terms, RBBB in V_1 is recognizable usually because the peak of the R′ appears *later* than 0.08 sec. after the onset of the QRS—well after normally activated right or left ventricle should have ceased firing. The development of an early R′ (its peak earlier than 0.08 sec. after the onset) is a clearcut indication that the right ventricle has enlarged rather than that conduction has been disordered. As indicated, the diagnostician should be alerted for the incipient early R′.

Even without the tell-tale R′, an R-wave larger than the S-wave on the right precordium readily suggests a diagnosis of right ventricular enlargement (RVE). A better general rule for early recognition of RVE is to look for a fall in R/S ratio between V_1-V_2, V_2-V_3 or occasionally V_3-V_4. This observation especially aids detection of RVE either of relatively mild degree or in the presence of concomitant left ventricular hypertrophy. Indeed, sometimes the only electrocardio-

graphic indication of RVE is the drop in R/S ratio as one moves away from the enlarged right ventricle toward the left ventricular apex.*

The development of a right precordial Q with excessive loading of the right heart has been attributed to a large atrium which interposes itself between the V_1 and V_2 positions and the large right ventricle. Thus, a "cavitary" potential is recorded as V_1 and V_2 "look" through the tricuspid ring.

Similarly, right heart dilatation is said to elevate the heart off the diaphragm and rotate the septum so as to add septal Q to the Q_3. Alternatively, frequent T-wave inversion in leads III and aV_f in acute right ventricular loading lends some credence to the supposition that a Q_3 T_3 pattern in acute cor pulmonale may relate to right coronary artery insufficiency or an ischemic mechanism associated with increased pressure on the subendocardium and its contained vessels.

Rhythm Disturbances

The individual with chronic lung disease is predisposed to arrhythmias and is sensitive to digitalis. Because of the extreme dyspnea, frequent cyanosis, occasionally palpable liver and rapid heart rate on mild exertion, the patient with severe pulmonary disease often is digitalized—sometimes mistakenly. Usual therapeutic endpoints are obscured because of the underlying lung disease. Additionally, there is good evidence that in chronic disease states and especially in pulmonary insufficiency, there is depletion of intracellular and total body potassium. In cor pulmonale, sensitivity to digitalis may arise from hypoxia and hypercapnea as well as from hypokalemia, the latter often implemented by diuretic agents.

Patients with obstructive lung disease often receive exogenous sympathetic amines superimposed on the endogenous release of epinephrine by respiratory acidosis. Isoproterenol hydrochloride, ephedrine, and epinephrine have all been shown to produce ventricular arrhythmias as well as the almost inevitable sinus tachycardia.

Of the multiple arrhythmias which have been noted to be associated with pulmonary disease, none is pathognomic and each is dependent upon the contributing factors, many of which are iatrogenic in nature. It is important for the physician to remember that those patients already functioning on a small cardiopulmonary reserve are *especially* prone to arrhythmias and profoundly vulnerable to their consequences.

Medical College of Georgia,
Veterans Administration Hospital

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* *It is important to exclude clinically and by other ECG criteria the presence of either anterior or strict posterior myocardial infarction which could produce reversal of the normal R/S ratio progression.*

COLUMBIA UNIVERSITY PRESENTS

POSTGRADUATE COURSE IN OB-GYN

The Department of Obstetrics and Gynecology of the College of Physicians and Surgeons, Columbia Unisersity in New York, will present a course in obstetrics and gynecology October 28 through November 1, 1968. The course will include a refresher course in obstetrical and gynecological pathology.

For additional information regarding registration, contact Equinn W. Munnell, M.D., FACOG, College of Physicians and Surgeons of Columbia University, 630 West 168th Street, New York, New York 10032.

Highlights of the AMA House of Delegates Meeting

Meeting as a part of the 117th Annual Convention of the American Medical Association in San Francisco, the AMA House of Delegates took many important actions on a wide variety of subjects. This report is intended as a summary only of the highlights of that meeting.

THE HOUSE MET, considered and disposed of 143 items of business, including 84 resolutions; 39 reports from the Board of Trustees; 7 from the Council on Constitution and Bylaws; 4 from the Council on Medical Education; 5 from the Council on Medical Service; 2 from the Judicial Council and 2 special reports.

Health Care Costs and Financing

A report of the Committee on Health Care Financing, transmitted by the Board, was accepted for information. It included background on the committee's findings and set forth, in part, directions for the future:

"Adequate health care should be available to all who need it. Recent scientific advances have served to vastly increase the demand for medical services and to increase health care expenditures. Methods of financing health care must aid all individuals to achieve the health services they need. Voluntary programs to finance the costs of health services must accommodate to continuing changes and growth."

Proposals under study by the committee include a community fiscal agency for health services, "not as a competitor for existing health insurance plans, but to complement those efforts and stimulate greater achievement"; and "income tax credits for the premiums paid for adequate health insurance . . . an effective and feasible method of encouraging maximal participation in voluntary comprehensive health insurance programs."

A resolution was subsequently adopted that "the principle of graduated income tax credits for premiums paid for adequate health insurance be adopted as approved policy of the AMA."

A Board report on the economics of health care, adopted by the House, pointed out that the Board "has approved a committee recommendation that a technical evaluation of the full potentialities of the AMA in the field of economics of health care be carried out by a small advisory group of competent, nationally recognized economists. It is expected that this will be done promptly."

In the area of reducing costs to patients, the House adopted a resolution that "the AMA endorse the principle of voluntary health insurance coverage for outpatient x-ray and laboratory services acceptable to the hospital and its medical staff wherever performed prior to a scheduled hospital admission."

Legislation and Relationship With Government

"With government increasingly involved in research and experiment in the delivery of health services and payment for care, we cannot ignore government programs. On the other hand, the multiplicity of programs and approaches at the national, state and local level precludes blanket endorsement of any given level of

involvement. The Council therefore recommends that this House make it clear that medical societies may, after mature consideration, legitimately take part in such programs . . . and that it should trust to the good sense of the individual state and county societies to recognize the serious import and the need for careful study before deciding on such a step."

The House also expressed its will that "The society should use some mechanism such as a nonprofit corporation or other entity, separate from the society itself and served by an independent administrative staff, where possible, to avoid direct operational involvement of the medical society as a body."

Three resolutions were introduced objecting to the government's support of group practice, particularly the prepayment type. They were combined into one substitute, "Resolved, that the AMA continue to espouse the private, fee-for-service practice of medicine; and be it further resolved that the AMA strongly disapproves of the provision of funds by the federal government for subsidizing any one form of organization of medical practice."

In addition, the House reaffirmed "previous policies requesting that all efforts be made to eliminate recertification requirements under" Medicare and called on the Congress "to amend the laws and regulations pertaining to PL 89-97 to specifically permit direct billing to all Title 19 recipients."

The House also resolved that "The Board . . . take appropriate action seeking the establishment of a separate Federal Department of Health headed by a Doctor of Medicine."

A resolution proposed that Congress establish within its control a "Committee on Rules and Policies of Federal Administrative Agencies" whose "responsibility it will be to review rules and policies promulgated by federal administrative agencies to determine that [they] are in accord with the legislative intent of the Congress." It was adopted in principle and referred to the Board and the Council on Legislative Activities.

Finally, in this category, the House resolved to call to the attention of state governors and other state and local officials "that the maintenance of medical treatment facilities and the care of all patients and hospital personnel in the event of a disaster is of prime and basic importance" and that "preliminary planning to provide such protection be a part of every disaster program."

Manpower

The House approved a Board report reviewing studies of the status of foreign medical graduates in the United States and directing the new Council on Health Manpower to take the steps necessary to complete plans for the organization and financial support of a commission, to be established outside of government, to coordinate fully all of the issues and activities involving foreign medical graduates.

The House referred to the Council on Medical Education a resolution protesting proposed changes in the Essentials for Accredited Schools of Medical Technology by the American Association of Clinical Pathologists which would eliminate approved schools of medical technology on the basis of size; and referred to the Board a resolution that osteopathic physicians be admitted to AMA approved hospital internship and residency programs under certain circumstances.

Also referred to the Board was a resolution to establish a joint commission on accreditation of nursing schools, with participation by the AMA, AHA, ANA and National League for Nursing.

Transplantation and Patient Care

A Judicial Council report was adopted on "Ethical Guidelines for Organ Transplantation." One of several important guidelines was, "When a vital, single organ is

to be transplanted, the death of the donor shall have been determined by at least one physician other than the recipient's physician. Death shall be determined by the clinical judgment of the physician. In making this determination, the ethical physician will use all available, currently accepted scientific tests."

A Council on Medical Service report on automated multiphasic screening, approved by the House, pointed out that tests used in "a multiphasic screening program should be relatively simple to administer, easy to interpret, relatively inexpensive and require little time to perform." All such screening programs should be subjected to the five criteria suggested by the former National Commission on Chronic Illness: reliability; validity; yield of information; cost; and acceptance by physicians, individual laymen and the community.

The House resolved, in connection with proposals for a national compendium of approved drugs, that "present quality standards imposed voluntarily by the American pharmaceutical industry should not be abridged or usurped by any federal agency, and . . . any drug compendium devised should be made available solely as a reference source of information."

The House adopted a Board report recommending AMA support for the use of the Slow-Moving Vehicle Emblem developed by Ohio State University for all vehicles, tractors, construction equipment or horse-drawn vehicles moving less than 25 miles per hour.

The House resolved to continue AMA "efforts to safeguard and inform the medical profession and the public with respect to the treatment of obesity."

It also referred to the AMA's policy on chiropractic and urged state and local medical societies "to formally adopt the AMA Policy Statement on Chiropractic, or a somewhat similar expression" and "to alert the general public to the health hazard posed by the cult of chiropractic."

Hospitals

Regarding use of paramedical personnel, the House recommended to the JCAH, AHA and its state and local chapters and to hospitals and other related facilities "that the practice of medicine . . . be preserved as the responsibility of the physician and that paramedical personnel not be placed in the position of practicing medicine whether by consent, design or contract"; and recommended "to the state and county medical societies and hospital staffs that they call attention to the dangers of contractural agreements which remove the services of paramedical personnel from the supervision of the physician."

Interruption

An interruption in the proceedings came Sunday afternoon during the opening session when two men seized a microphone in front of the podium and insisted on addressing the House.

One was a senior medical student from Stanford, representing the Medical Committee on Human Rights; the other a welfare worker and official of the Bay Area Poor People's Campaign. Speaker Bornemeier maintained order while the two men took turns speaking for a total of 13 minutes.

Tuesday, a written statement was presented to Speaker Bornemeier setting forth the objectives of the Medical Committee on Human Rights. He read it to the House as a matter of information.

NEW MEMBERS

Blackston, Ronald D., M.D. Active—DeKalb	1365 Clifton Road, N.E. Atlanta, Georgia 30322
Burkhart, J. M., M.D. Active—Richmond	1140 Druid Park Avenue Augusta, Georgia 30904
Dressler, Marion S., M.D. Active—DeKalb	126 Trinity Place, West Decatur, Georgia 30030
Espy, Goodman B., III, M.D. Active—Cobb	114 Cherry Street Marietta, Georgia 30060
Houston, Joseph S., M.D. Active—South Georgia	305 Emory Street Valdosta, Georgia 31603
Jones, George R., M.D. DE-4—DeKalb	Ft. McPherson Army Hospital Fort McPherson, Georgia 30330
Kilpatrick, Zachary, M.D. Active—Richmond	Medical College of Georgia Augusta, Georgia 30902
Mendoza, Jose A. G., M.D. Active—Baldwin	Central State Hospital Milledgeville, Georgia 31062
Montana, Eduardo, M.D. Active—Floyd	16 Hospital Circle Rome, Georgia 30161
Smith, Reuben J., M.D. Active—Crawford W. Long	740 Prince Avenue Athens, Georgia 30601
Sprouse, James H., Jr., M.D. Active—Cobb	792 Church Street Ext. Marietta, Georgia 30062
Sussman, Hy C., M.D. Active—Richmond	Medical College of Georgia Augusta, Georgia 30902
Swingle, Roger L., M.D. Active—Crawford W. Long	2010 S. Lumpkin Street Athens, Georgia 30601
Tillman, Billups P., M.D. DE-4—Crawford W. Long	2010 S. Lumpkin Street Athens, Georgia 30601
Torrance, Clarence B., M.D. DE-2—DeKalb	4511 Chamblee Dunwoody Road Chamblee, Georgia 30005
Williams, James D., M.D. DE-2—DeKalb	4511 Chamblee Dunwoody Road Chamblee, Georgia 30005

SOCIETIES

F. Dempsey Guillebeau, president of the **Dougherty County Medical Society,** endorsed the U. S. government's campaign to warn the public of the harmful effects of moonshine whiskey. Dr. Guillebeau said 97 per cent of the moonshine found in this area contains deadly lead salts poison which can cause brain damage, stomach cramps, paralysis, anemia and other physical defects, in addition to death.

The **Bibb County Medical Society** has endorsed plans for expanding Macon Hospital, and has expressed hope of "a continuing study of the future medical needs of this community." In a resolution, the organization said it "resolved that this society join with the staff of the Macon Hospital in its support of the plans."

Politics and politicians were on the agenda of the June meeting of the **Georgia Medical Society.** The topic, "The Doctor and the Doctor's Wife in Politics," brought together for discussion local physicians and area and State political figures.

The **Sixth District Medical Society** met in Newnan on July 17 to hear J. Gordon Barrow discuss "The Progress of the Regional Medical Program in Georgia."

PERSONALS

First District

A Planned Parenthood Association has been organized in Savannah and has applied for affiliation with the national association. **John Angell** was elected chairman of the organization. Also elected to the board were **Lee Howard, Jr., William Osborne, W. D. Lundquist** and **Walter W. Otto.**

Stephen M. McDew of Savannah has been elected president of the Georgia State Medical Association. The announcement was made at the association's 75th annual meeting held in Atlanta in June.

Second District

E. E. Davis, a Thomasville physician, was awarded a Certificate of Commendation and Appreciation by the Chamber of Commerce for his "outstanding work" with the Thomas County Selective Service Board.

Third District

The Medical Staff of the R. J. Taylor Memorial Hospital has announced the election of **Hart Sylvester** of Hawkinsville as the new chief of staff. **W. E. Coleman** was elected vice chief of staff, and **W. R. Baker** was elected secretary-treasurer.

John H. Robinson, III, of Americus has been elected chairman of the Americus Board of Education at a meeting held in late May.

Dr. and Mrs. J. C. Serrato, Jr., of Columbus were guests at a dinner at the White House at which President and Mrs. Johnson entertained Australian Prime Minister and Mrs. John Gorton.

Fourth District

The Decatur Lions Club presented its Senior Citizen Award for outstanding community service to **J. Rufus**

Evans, chairman of the DeKalb County Board of Health. Dr. Evans, of Stone Mountain, chairman of the DeKalb County Hospital Authority, was health officer with the DeKalb County Health Department for 24 years. He became chairman of the DeKalb Board of Health in 1952.

Fifth District

Irene A. Phrydas, assistant professor in psychiatry at Emory University School of Medicine attended the interim meeting of the American Medical Women's Association in New York City on June 20 and 21.

South Fulton Hospital has announced the election of **Julius Pierotti** as Chief of the Medical Dental Staff at the hospital. The elections took place in June.

John H. Venable, Health Department Director, was a featured speaker at a recent meeting of the Georgia Committee on Children and Youth. "No child, no young person can grow up to fulfill the challenge of successful living without good health. As we view it, he shouldn't have to try," said Dr. Venable.

Carl R. Hartrampf, Jr., of Atlanta announces the association of **Dr. Paul W. Black** in the practice of plastic and reconstructive surgery.

At the recent meeting of the American Medical Association in San Francisco, **Sidney Olansky** was awarded an "oscar" for his performance in the AMA Bowl Quiz. Dr. Olansky represented the Southern team and answered questions related more to government than to medicine.

The old Fairmount Clinic, which has been unused for a number of years has been renovated for **Baird Hudgens** of Atlanta. Dr. Hudgens and his associates have established office hours at the clinic which is owned by the City of Fairmount.

J. Willis Hurst and **Dan Burge** of Atlanta have been chosen to represent various community groups involved in the production of the "Georgia Heart Hour." The program is presented by the Georgia Heart Association and is telecast twice monthly to State physicians. Also involved in the production of the educational television program are **Louis L. Battey** of Augusta and **Goodloe Y. Erwin** of Athens.

Sixth District

The Macon News commended **Beveryl W. Forester** on his active participation in community affairs. The editorial also congratulated Dr. Forester on his new position as chairman of the Board of Health. He will serve a two-year term succeeding **P. K. Dixon** of Gainesville.

Seventh District

In June, **Tom Harbin** of Rome participated in the Second International Symposium on Microsurgery of the Eye. The meeting was held at Burgenstock, Switzerland.

Eighth District

Robert Perry, a pathologist at the Brunswick Hospital, was featured in a news story about the new Autoanalyzer installed there. Dr. Perry praised the hospital authority for approving installation of the machine which cuts drastically the costs for blood tests.

Ninth District

The Ninth Congressional district of Veterans of Foreign Wars elected **Charles R. Andrews** to the office of District Surgeon. Dr. Andrews has served the VFW for many years in Post, District, Department and national positions.

John W. Acree of Hiawassee was one of three new members elected to the board of Young Harris College. The announcement followed the semi-annual meeting of the board of trustees held in June.

Tenth District

The dean of the Medical College of Georgia, **Walter G. Rice,** has been named director of the division of operational studies of the Association of American Medical Colleges.

Victor A. Moore has been selected to speak at the first annual meeting of the Lahey Clinic Foundation Alumni Association to be held in Boston this fall. Dr. Moore will deliver a paper on "Clinical Situations in which Angiography and Scanning Techniques May Be of Value."

Abe J. Davis, director of public health in Augusta and Richmond Counties was featured in a news article on the health hazards of slums. Eliminating this substandard housing, said Dr. Davis, is one of the best foundations for good health.

Robert B. Greenblatt was one of five U.S. physicians whose comments on estrogen treatment of menopausal women were included in the June 17 issue of *Modern Medicine.*

DEATHS

Hollis Elwood Puckett

Hollis Puckett, a general practitioner in Savannah since 1951 died May 5 at Memorial Medical Center as a result of heart complications.

Dr. Puckett was an avid sports fan, and is particularly remembered as the "official" physician for the Savannah High School football team. He was also an energetic member of the Wilder Junior High School Parent-Teacher Association (of which he was immediate past president), the Kiwanis Club, the Savannah Yacht and Country Club, Phi Chi medical fraternity, and the Savannah Gridiron Club.

A native of Louisville, Kentucky, Dr. Puckett received his medical degree from the University of Louisville and interned at Walter Reed Army Hospital. He served on the staffs of Candler General Hospital, Memorial Medical Center and Oglethorpe Sanitorium. He was a member of the Georgia Medical Society, the Southern Medical Association, the Medical Association of Georgia, and the American Academy of General Practice.

Surviving are his wife Mrs. Elsbeth Burnham Puckett; two daughters, Elsbeth Camille Puckett and Suzanne Puckett; and a son Hollis Elwood Puckett, Jr., all of Savannah.

ANDROGENIC ANABOLIC STEROIDS

The following report was prepared by the Committee on the Medical Aspects of Sports of the American Medical Association. The MAG Committee on School Child Health voted to endorse the statement, as read and reviewed by Dr. Fred Allman, committee chairman. Dr. Robert Greenblatt prepared the preface for publication in the Journal.

A steroid with anabolic features and minimal androgenic properties has been the goal of chemists and pharmacologists for many years. During the past decade, new preparations have become available with a more favorable anabolic-androgen ratio. The use of such agents to fatten and strengthen healthy adolescent boys engaged in athletics is an abuse of therapy and an injudicious extension of medical license.

Valid Uses

There is indeed an area for judicious employment of anabolic agents in the various fields of medicine. These may be employed to improve appetite in the underweight and malnourished children and adults, and to offset the catabolic action of chronic glucocorticoid therapy.

When prescribed in prepubescent and pubescent children for retarded growth or development, anabolic agents should be administered in small doses for 30 days, followed by 30-day therapy-free intervals in order to minimize rapid genital development and signs of androgenicity. When such a regimen is followed, linear growth will be enhanced without undue advance of bone age. Thus increased height may be obtained earlier when it is more meaningful, although there is no proof that ultimate height will be greater than that destined for the individual.

When personality problems are of some concern because of diminished stature, anabolic agents may be used to good advantage, provided the therapy is undertaken under the direction of physicians knowledgeable in the field of growth and development.

The Statement

"Androgenic anabolic steroids, sometimes used by athletes for inducing weight gain, should be condemned except for certain specific clinical conditions. Under no circumstance should these drugs be used for the intended purpose of promoting athletic achievement.

"Aside from the ethical aspect of using drugs for non-clinically justified purposes, the potentially serious health hazard involved makes these drugs totally undesirable for use by athletes. In prepubertal boys the steroids may prematurely stop growth, induce precocious puberty and result in decreased testicular size. In the pubertal male, the steroids markedly suppress production of testosterone. In adult males, testicular size and function revert to the prepubertal stage, and there is decreased libido. Oral doses of the steroids have produced changes in liver function in all age groups.

"Although androgenic anabolic steroids are proposed for use in various pediatric disorders marked by retarded growth, weakness and malnutrition, such use in children and young adults should be undertaken only after consultation with *experts* on *growth* and *development*. Although small doses are claimed to bring about weight increases in underweight children and to accelerate growth in some children with growth retardation, the possibilities that virilization and acceleration of bone maturation may occur must be considered, if a course of therapy causes a greater rate of skeletal maturation than linear growth, a reduction in the otherwise attainable adult height may result from premature closure of the epiphyses.

"It should also be pointed out that a recently completed study showed no significant performance difference between athletes who received an anabolic steroid and others who received a placebo."

THE MONTH IN WASHINGTON

President Johnson designated the Secretary of Health, Education and Welfare, Wilbur J. Cohen, as the chief Federal official for health policies and programs.

An HEW reorganization plan, recommended by Cohen and approved by Mr. Johnson, makes the secretary:

1) The President's chief adviser on Federal health policy and programs.

2) Responsible for coordinating all Federal health programs.

3) Head of a new Federal Interdepartmental Health Policy Council.

The reorganization also included creation of a Consumer Protection and Environmental Health Service as a unit of the Public Health Service and transfer of the Division of Regional Medical Programs from the National Institutes of Health to the Health Services and Mental Health Administration.

Mr. Johnson also agreed to renew a request to Congress to raise the status of HEW's principal health official, now Dr. Philip R. Lee, from assistant secretary to Under Secretary for Health and Science.

The new consumer and environmental health unit consists of:

—The Food and Drug Administration;

—The National Center for Air Pollution Control;

—The National Center for Radiological Health;

—The National Center for Urban and Industrial Health;

—Certain staff units of the Office of the Director, Bureau of Disease Prevention and Environmental Control.

Charles C. Johnson, Jr., a Negro and Assistant Commissioner for Health for Environmental Health in New York City, was named to head the new unit.

New Food and Drug Commissioner

Dr. Herbert L. Ley, Jr., who had been director of the FDA's Bureau of Medicine since the fall of 1966, was appointed to succeed Dr. James L. Goddard who recently resigned as Commissioner of Food and Drugs. Dr. Ley, 44, had been recommended by Goddard and also had the support of a number of Senate and House members on committees concerned with FDA. A 1946 graduate of the Harvard Medical School, Dr. Ley had been on the faculty at his alma mater and the George Washington University School of Medicine earlier in his career. He also had served as chief of medical branches of the Army research office and the office of the Army Surgeon General.

The interdepartmental health policy council will oversee all Federal activities in the health field, such as the drafting of physicians for service with the armed forces, Veterans Administration hospitals and Office of Economic Opportunity health projects.

Drafting of Physicians

Cohen said that there had been no way in the past for the HEW secretary to give guidance in such matters. He said there must be a reexamination of the drafting of physicians to provide care in the United States for civilian dependents of military personnel.

"This allocation of a portion of the critically scarce physician pool materially affects programs intended to make health care as widely available as possible, a national health goal that goes far beyond the mission of the Department of Defense," Cohen said.

Extension of Medicare

As medicare went into its third year, Cohen announced the appointment of a 12-member advisory council to study the possible extension of the program to disabled persons under age 65. Congress last year turned down the administration's request for such an extension but authorized creation of the council to study the matter.

In discussing medicare, Cohen said rising health care costs had made financing of the program a serious problem. He said new financing, presumably a tax increase, may be required if costs continue to rise.

Dr. Henry H. Kessler, director of the Kessler Institute for Rehabilitation in Newark, N.J., was named chairman of the advisory council. Other members are:

Dr. Morris Brand, medical director of the Sidney Hillman Health Center; James Brindle, president of the Health Insurance Plan of Greater New York; James M. Gillen, director of personnel research of General Motors; Juanita Kreps, associate professor of economics at Duke University; Dr. Leonard W. Larson, past president of the American Medical Association; Daniel W. Pattengill, vice president of Aetna Life and Casualty Co.; Bert Seidman, director of the AFL-CIO social security department; E. A. Vaughn, vice president of the Aluminum Co. of America; Anthony G. Weinlein, executive assistant to the president of the AFL-CIO Building Service Employes; E. B. Whitten, executive director of the National Rehabilitation Assn., and Dr. Alonzo S. Yerby, professor at Harvard's School of Public Health.

AMA Position on Federal Bill

The American Medical Association told Congress it supported most provisions of the administration's health manpower bill as essential to increasing enrollment in the nation's medical schools.

The AMA position was outlined by Dr. William A. Sodeman of the AMA's Council on Medical Education in testimony before the House Public Health and Welfare Subcommittee. He noted that a recent joint statement of the AMA and the Association of American Medical Colleges that more funds from both government and private sources would be needed by medical schools if they were to expand enrollment.

"The bill (H.R. 15757) before the subcommittee provides a means of furnishing the Federal component of the necessary financial resources," Dr. Sodeman said.

In other testimony, the AMA supported the overall objectives of the Administration's occupational health bill. But the Association opposed a provision that would authorize establishment and enforcement of mandatory national standards for health and safety.

Urging rejection of the mandatory standards provision, Dr. Wells said that this authority has been "properly vested in the states where the standards and the enforcement can be adapted to their particular geographical and industrial conditions."

High Court Decision on Alcoholics

The U.S. Supreme Court refused, by a 5-4 division, to lay down a constitutional rule against punishing chronic alcoholics for being drunk in public.

In an opinion by Justice Thurgood Marshall, four members of the Court said that neither the facts of the test case nor "the comparatively primitive state" of scientific knowledge on the subject justifies such a decision at present.

The vote of the four, plus Justice Byron R. White, who concurred separately, upheld the conviction of Leroy Powell, 67, who was fined $50 in a Travis County, Tex., court for being drunk in public. The argument for Powell was that alcoholism is a disease and the person suffering from it should be treated rather than punished.

Two AMA authorities on alcoholism expressed surprise and disappointment at the court's decision. Dr. Marvin Block of Buffalo, N.Y., a member and former chairman of the AMA's Committee on Alcoholism and Drug Abuse, and Dr. Dana L. Farnsworth of Harvard University, chairman of the AMA Council on Mental Health took issue with the court opinion that "we are unable to conclude . . . that chronic alcoholics in general . . . suffer from such an irresistible compulsion to drink and get drunk in public that they are utterly unable to control their performance . . . ."

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1968 CALENDAR OF MEETINGS

September 7-8, 1968—**MAG Committee Conclave, Marriott Motor Hotel, Atlanta.**

October 29-November 1—American Society of Tropical Medicine and Hygiene, Biltmore Hotel, Atlanta.

December 6-7—American Rheumatism Association, Regency-Hyatt House Hotel, Atlanta.

National

August 22-24—National Cancer Conference, Park Motor Inn, Madison, Wisconsin.

August 25-30—American Physiological Society (International Congress), Washington, D.C.

August 26-31—International Congress on Photobiology, Dartmouth College, Hanover, New Hampshire.

August 26-30—Postgraduate Course in Dermal Pathology, Houston, Texas.

August 28-30—Society for the Study of Reproduction, Vanderbilt University, Nashville, Tennessee.

September 1-6—American Society of Hematology, Waldorf-Astoria, New York, New York.

September 1-6—International Society of Hematology, Waldorf-Astoria, New York, New York.

September 5-7—American Association of Obstetricians and Gynecologists, The Homestead, Hot Springs, Virginia.

September 6-7—Ninth Annual Cardiovascular Symposium, Lake Wright Motel, Virginia Beach, Virginia.

September 7-11—International Congress of the Transplantation Society, Americana Hotel, New York, New York.

September 13-20—American Academy of General Practice, Las Vegas, Nevada.

September 15-20—International Congress on Alcohol and Alcoholism, Shoreham Hotel, Washington, D.C.

September 18-20—National Cancer Conference, Denver Hilton Hotel, Denver, Colorado.

September 19-22—American Medical Writers Association, Mayflower Hotel, Washington, D.C.

September 22-24—Medical Progress Assembly, Parliament House, Birmingham, Alabama (14 Hours Category 1 AAGP Credit).

September 25-27—American Association of Medical Clinics, The Roosevelt, New Orleans, Louisiana.

September 27-28—American Society of Neuroradiology, Jung Hotel, New Orleans, Louisiana.

September 28-October 3—International College of Surgeons, United States Section, Honolulu, Hawaii.

September 30-October 1—AMA Congress on Occupational Health, New York, New York.

October 1-4—American Roentgen Ray Society, Jung Hotel, New Orleans, Louisiana.

October 2-4—Clinical Orthopaedic Society, Roosevelt Hotel, New Orleans, Louisiana.

October 4-8—International Congress on Diseases of the Chest, Washington-Hilton Hotel, Washington, D.C.

October 5-6—AMA National Congress on Medical Ethics, Drake Hotel, Chicago, Illinois.

October 11-19—American Society of Clinical Pathologists, Fontainebleau Hotel, Miami Beach, Florida.

October 12-18—College of American Pathologists, Fontainebleau Hotel, Miami Beach, Florida.

October 14-18—American College of Surgeons, Dennis Hotel, Atlantic City, New Jersey.

October 17-19—Association of American Physicians and Surgeons, Roosevelt Hotel, New Orleans, Louisiana.

October 19-24—American Academy of Pediatrics, Palmer House, Chicago, Illinois.

October 19-23—Annual Meeting of American Society of Anesthesiologists, Washington-Hilton Hotel, Washington, D.C.

October 20-21—American Association of Poison Control Centers, Palmer House, Chicago, Illinois.

October 27-November 1—American Society of Plastic and Reconstructive Surgeons, Roosevelt Hotel, New Orleans, Louisiana.

October 27-November 1—American Academy of Ophthalmology and Otolaryngology, Palmer House, Chicago, Illinois.

November 1-4—Association of American Medical Colleges, Shamrock Hilton, Houston, Texas.

November 7-9—Second Annual Conference on "Today's Hospital Problems: An Interdisciplinary Approach," Tides Hotel and Bath Club, Redington Beach, Florida (18 accredited hours by AAGP).

November 7-10—Association of Clinical Scientists, Shoreham Hotel, Washington, D.C.

November 14-16—Southern Thoracic Surgical Association, Puerto Rican Sheraton, San Juan, Puerto Rico.

November 18-21—Southern Medical Association, The Rivergate, New Orleans, Louisiana.

November 19-20—Council on Arteriosclerosis, Balmoral Hotel, Bal Harbour, Florida.

November 21-26—American Heart Association, Americana Hotel, Bal Harbour, Florida.

November 29-30—National Federation of Catholic Physicians' Guilds, Miami Beach, Florida.

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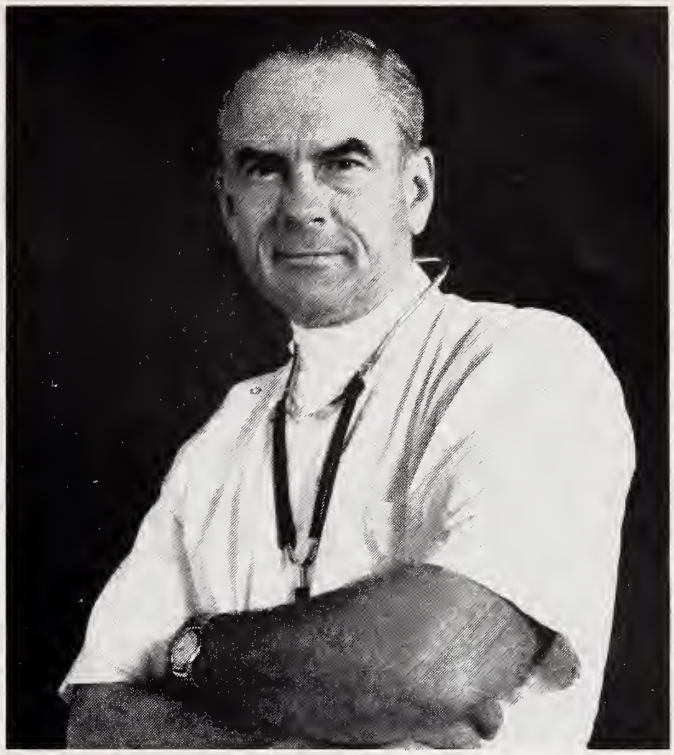

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A CASE OF PUERPERAL TETANUS, FOLLOWING CRANIOTOMY

BY ARTHUR C. DAVIDSON, M.D., SHARON, GA.

Mrs. Mary C.; age twenty; primipara; of rather delicate constitution and moderate health, was taken in labor, February 7th, 1888.

Labor progressed rather slowly during the day and night, but came on very decidedly on the morning of the 8th.

Toward noon of this day, the expulsive pains were so severe, without giving any promise of relief, her physician thought best to call for consultation and aid.

I was summoned, and arrived about 3 o'clock p.m., and found patient suffering very much, both physically and mentally. Upon making a vaginal examination, the os was found to be fully dilated, and the vertex presenting; the external parts, vulva, and vaginal tract were yielding and soft; pains coming on about every five minutes, and exceedingly severe, so much so that the patient would scream out with anguish.

Elliott's forceps were applied once, and Barnes' forceps twice, in the space of four hours, without avail, notwithstanding there seemed to be no narrowness or contraction in the pelvic space.

It was now thought best to deliver by sacrificial midwifery, if, indeed, the fetus was yet alive. Accordingly, at 8 p.m., the patient being thoroughly anesthetized, I proceeded to practice craniotomy, and in about a hour succeeded in delivering a fine, large male child.

The placenta came away intact—slipping out; the uterus contracting promptly, there was very little hemorrhage.

Having prepared the bed with clean, warm linen, the patient, being also dressed, was put to bed, and made comfortable by the aid of an opiate.

She slept very soundly all night, and expressed herself as feeling quite comfortable the next morning, except that the calves seemed to cramp her some and were a little sore.

She had some fever the next few days, and the soreness and stiffness in the legs had increased, and the muscles of the arms and neck and abdomen were also involved.

There was also a continuous disposition to yawn, accompanied by pain along the course of the trapezius muscle. She frequently complained of a peculiar feeling in her head and neck, and said they felt all the time like they wanted to fall backwards.

There was a slight sore throat from the second day after her delivery, which increased from day to day, and on the morning of the 13th there was some difficulty in swallowing.

These conditions becoming so much aggravated—tetanus being suspected—another old and very intelligent physician was summoned on the morning of the 14th.

Notwithstanding the fact that every thing of a therapeutic nature, pertaining to the treatment of such a malady, were tested and pushed to their fullest, even to almost toxic effect, our patient grew rapidly worse from hour to hour, and died a little after midnight.

Convulsions set in early in the evening, and increased with such rapidity and force that, before death came to her relief, scarcely one minute would intervene between seizures, the least noise arousing a spasm.

The characteristic sardonic smile was prominent, and was noticed and remarked by quite a number of her friends, who did not understand its fearful import.

She was entirely unconscious during the last three hours of her existence.

It is scarcely necessary to state that every antiseptic precaution had been taken from the very beginning of the case, and the utmost care practiced with regard to cleanliness.

Puerperal tetanus is a disease of very rare occurrence, and very little is mentioned concerning it by writers upon obstetrical and gynecological subjects. In searching for literature upon the subject, every gynecological and obstetrical author within my reach is entirely silent upon the subject.

In Pepper's System of Medicine, a very small space is devoted to it, and the latest edition of Loomis' Practical Medicine has only this to say: "It may occur after abortion or normal delivery."

The etiology of tetanus is absolutely unknown. Dr. Shakspeare to the contrary, notwithstanding.

The late lamented Prof. L. A. Dugas, of Augusta, entertained the most practical views of tetanus, and from his lectures more sound, solid information could be obtained than from any source with which this writer is acquainted. He taught that tetanus was essentially a disease of the nervous system and non-infectious, and was always caused by a traumatism.

Later day scientists, if they cannot find a germ at the bottom of all diseases, are almost ready to deny the existence of the disease; and tetanus, with them, is not excepted.

From the Transactions of the Medical Association of Georgia, Thirty-Ninth Annual Session, 1888, Macon, Georgia.

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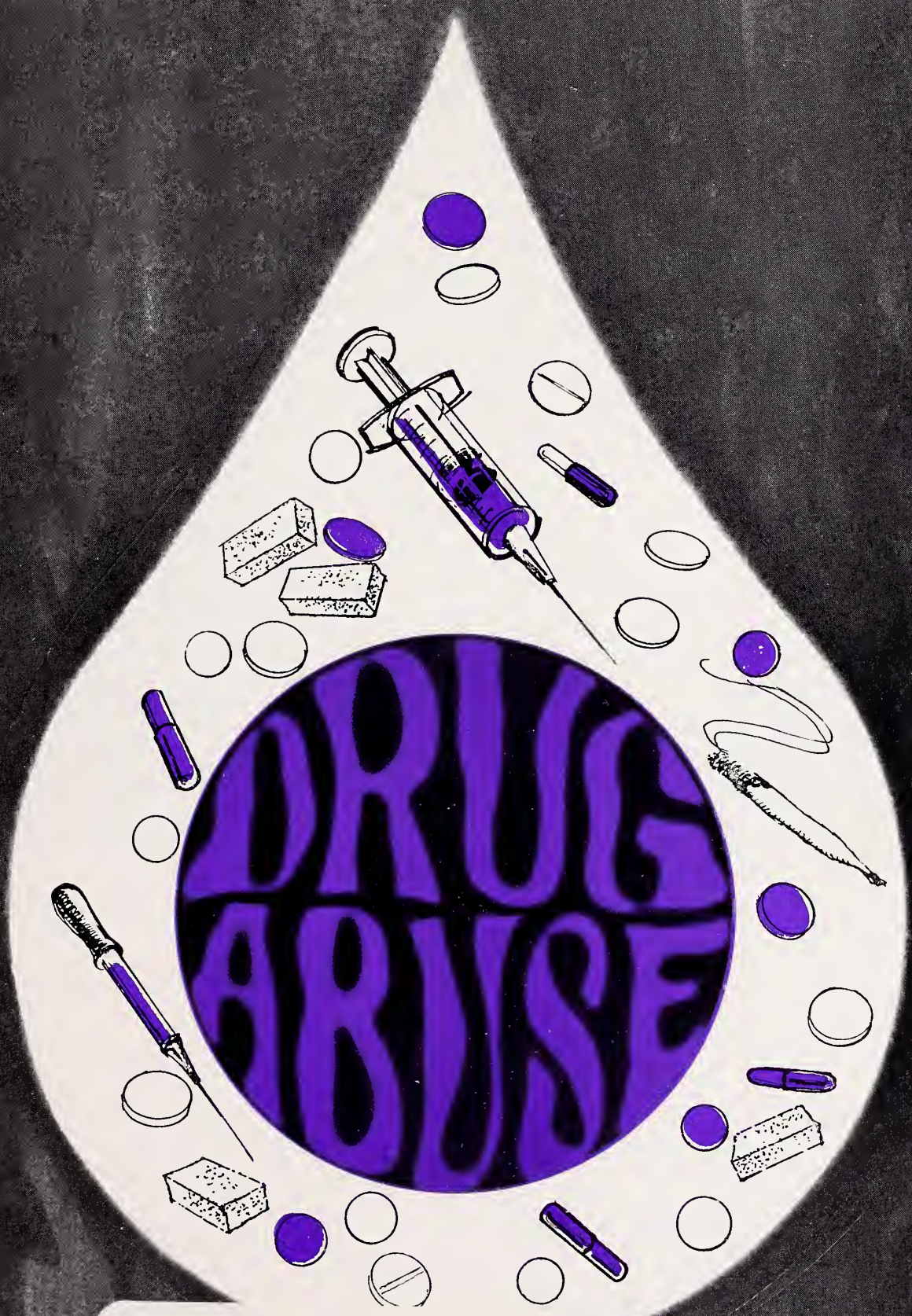

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JOURNAL OF THE MEDICAL ASSOCIATION Georgia

The systematic use of the tuberculin skin test can be a crucial step toward the prevention of major illness.

Chemoprophylaxis in Tuberculosis

RUFUS F. PAYNE, M.D.,* *Augusta*

THE PRACTICING PHYSICIAN is now in position to exert a tremendous influence on the prevention of tuberculosis. To understand what can be accomplished in decreasing the incidence however, he must have a clear concept of the dynamics of the disease in the population. From data gathered and evaluated by the United States Public Health Service in their studies, we now have a rather complete knowledge of how the disease develops and spreads in the community, and we also are in a position in which we can better define risk as it applies to the individual patient.

Public Health Service Statistics

From their evaluation of data we now know that approximately 40,000 new cases of tuberculosis, or about 80 per cent of all the new cases during the next year, will develop among those persons who have previously been infected with tuberculosis and who can be indentified through their hypersensitivity reaction to tuberculin. We know that these 40,000 persons will infect an average of three new cases each and from these 120,000 newly infected persons there will develop within the next year approximately 10,000 new cases of tuberculosis. This establishes immediately two very important facts.

First, is the fact that BCG vaccination would have no effect in preventing these 40,000 new cases since they have already been infected and have developed all the protection possible from a natural infection. Secondly, we know that we are dealing with two groups of persons in whom there is a marked difference in risk. For example, the newly infected adult will have a risk within the first year after infection about 50 times the risk during the next several years after his infection.

Since BCG vaccination will not be effective, is there an effective prophylactic agent? The ideal prophylactic agent would be one in which the drug would be taken only for a very short time, preferably in one dose. It should be easily administered, nontoxic and available at a reasonable cost. Most important of course would be the requirement that it must be effective.

Isoniazid as a Prophylactic Agent

There is no drug which meets all these criteria but isoniazid meets all of them except the requirement that the drug be taken in only one or very few doses. The results of prophylaxis with isoniazid have been so well documented in the prophylaxis trials carried out by the United States Public Health Service that I will mention them only briefly.

Patients selected for these studies were skin tested, X-rayed and, whenever possible, their history of ex-

Presented before the Chest Section Meeting, 114th Annual Session of the Medical Association of Georgia, Augusta, May 5, 1968.

* *Dr. Payne is Director, Hospital Research and Development at the Medical College of Georgia.*

posure was documented. They were then assigned, through random methods, to take either Inah or placebo pills. Neither the patient, the physician, nor the evaluator had any knowledge of whether the patient was given isoniazid or placebo.

No Severe Reactions

If the patient was assigned isoniazid, the drug was given in dosages of four to six milligrams per kilo per day, with a limit of 300 milligrams being given and the drug was continued for a duration of one year. There were no severe toxic effects noted except in one instance among epileptics in one of the institutions in which the study was carried out. As we have continued the use of the drug as a prophylactic agent we have been impressed with the fact that there are probably more evidences of toxicity in adults than among children but there is no valid evidence which indicates that a 300 mgm dose of isoniazid daily is likely to induce any nonreversible or severe reaction.

Any discussion of the effectiveness of the drug must concern itself with the type of patient to whom the drug was given, because we have already pointed out the fact that the risk of persons developing tuberculosis varies markedly among individuals.

The question of whether the drug should be given to persons whose tuberculin test is negative but who are exposed to an active case of tuberculosis cannot be answered with the expectation that there will be universal agreement. The experimental evidence indicates that the drug is quite effective when given to this group, but the evidence collected in the Public Health Service studies, in our opinion, is not adequate to answer this question. We use primary prophylaxis in very young children or in individuals who are at high risk because of some other factor, such as ingestion of steroids coupled with exposure.

Dramatic Results Among Children

The first controlled trial using isoniazid as prophylaxis was carried out among children and was directed primarily toward a determination of whether or not the drug would be effective in preventing complications, particularly meningitis. There were about 3,000 children in the study and it furnished such dramatic proof of the effectiveness of the drug that one is no longer justified in withholding the drug from those children in whom there is evidence that they have a true tuberculin hypersensitivity.

A moment ago I alluded to the fact that there was some question as to whether primary prophylaxis was justified or not and we, as well as others, have had the experience in which we could show that recent converters reverted to a negative tuberculin test in possibly 80 per cent of the cases after 6 to 12 months of isoniazid. This makes us feel personally that a contact in a home in which there is tuberculosis might be safer to have a controlled primary infection treated with isoniazid, than to be given the drug before conversion of his skin test and never have the benefit of generating an immunity from natural infection.

Effective Against Primary Infection

Another group in whom prophylaxis has been most effective are those persons who are under exposure now or recently to a source case with a positive sputum. While many of these are children, there are many others who are adults, and it is to this group that the physician should pay particular attention.

The risk of an adult developing significant clinical disease following primary infection is actually greater than that of a child, unless the child be under one, or possibly under two, years of age. I am not referring to the latent risk of tuberculosis which may not develop for 20 years or longer, but I am speaking particularly of the immediate risk. It has not been too many years since a high proportion of all adults had already converted their tuberculin test from negative to positive, and there are not too many articles in the literature which show the high risk of primary tuberculosis. The study of Palmer among student nurses is the best controlled study to date on this subject and it indicates that the risk of significant disease may be as high as 10 to 12 per cent if primary infection occurs in females of the age to be expected in a class of student nurses.

Increased Risk in Adults

The other factors that we mentioned earlier that applied to children apply even more noticeably to adults. Risk is markedly increased by evidence of the residuals of a primary infection, other than the presence of calcium in the hilum. Individuals who are under normal weight, persons with diabetes or gastric resection and particularly persons under therapy with steroids all have markedly increased risk as do persons who have large reactions to tuberculin skin tests.

Controversy Over Endogenous Disease

We have discussed, up to this time, the prophylaxis of primary tuberculosis in the main. This is not the group however in which the largest number of cases occur, although it is the group in which there is the highest risk per person per year. Any discussion of adult type tuberculosis must recognize the controversy that has existed for many years as to whether or not endogenous disease was responsible

for a large proportion of cases. Behring stated many years ago that adult tuberculosis was the last stanza of a song, the first stanza of which was sung to the child in the cradle. We have known for many years that the disease was disseminated rather widely into the apices during the anergic phase of the primary infection. These lesions were described by Simon and others and they generally bear the name Simon foci.

Although studies in Williamson County, Tennessee, showed many years ago that the highest risk of developing tuberculosis was associated with the presence of X-ray shadows of inactive disease in the apices, the overwhelming statistical and epidemiologic support for the endogenous origin of most adult tuberculosis has accumulated in recent years. We have X-rays on patients which demonstrated lesions in the apices that had no detectable changes for a period of as many as 20 years before they suddenly showed signs of activity and cavitary tuberculosis developed. We have seen other X-rays showing what appeared to be well circumscribed tuberculomas that suddenly drain into the bronchi, and on one occasion we have isolated tubercle bacilli from the patient.

Observations in Muscogee County

These same observations were described by Comstock in the Muscogee County studies during the latter part of the 1940s and the early 1950s and have most recently been described in greater depth and detail by Stead in Milwaukee, Wisconsin. Here, as in primary tuberculosis, we can assess risk for large population groups in such a manner that we can identify those persons whose risk justifies the adoption of special measures for either early diagnosis or for prophylaxis. The following factors have been found to be of significance and are, in general, the same factors associated with the risk of household contacts developing tuberculosis:

Significant Factors

(1) The presence of X-ray shadows caused by previous tuberculous infection is the factor of the greatest significance. The high degree of risk for patients whose tuberculosis was not treated with drugs has been known for many years, and has been confirmed in all of the studies of which we have knowledge.

Size of Skin Test Reaction

(2) The size of the Mantoux skin test reaction is a significant factor indicating whether or not the individual is likely to develop active tuberculosis. A good example is the record of annual cases per 100,000 persons in Muscogee County during the 10 years of the BCG study. The rate in persons having a skin test reaction less than 5 mm was 19 for white and 43 for colored. In the white group this showed an increase to 105 for those persons having a reaction greater than 15 mm, whereas in the colored race, the rate increased to 174 for those having skin test reactions over 15 mms.

Time Elapsed

(3) The length of time since the infection took place also has considerable influence on risk. We noted in a 10-year study in Richmond County that the risk is significantly higher in the first year and shows a decrease for three or four years, after which it levels out to remain at a fairly constant rate. A chemoprophylaxis study of the United States Public Health Service also showed there were 19 active cases per 1,000 among contacts at the first examination, with the rate dropping to eight per 1,000 in succeeding years.

Below Average Weight

(4) Studies in previous years have shown that persons whose weight is 10 per cent or more under the average for height and age have a twofold risk of developing tuberculosis. This same correlation held true for those persons who were on the controlled chemoprophylaxis trials of the United States Public Health Service.

Silicosis

(5) The effect of silicosis upon developing tuberculosis has been observed clinically for many, many years. Until the advent of drugs, it was rare to see any patient recover from tuberculosis who had silicosis. There is no question that this risk still holds true and, to a lesser degree, we see the same thing in persons with other types of pneumoconiosis.

Clinical experience, as well as many surveys, have shown the association between diabetes and tuberculosis. Physicians treating diabetics should repeat the tuberculin skin tests regularly, if they are negative, so that the time of conversion will be known. It appears that there is increased risk in developing tuberculosis after gastric resection. Acute intercurrent infections, particularly measles and influenza, have been associated with breakdown of latent tuberculosis for many years. The development of an increased number of cases of miliary or meningeal tuberculosis is frequently noted after a measle epidemic. Skin test studies have shown that intercurrent infections cause a skin test to revert from positive to negative and there are many persons who feel that this loss of hypersensitivity is a factor that causes the disease to spread from a latent focus.

Use of Steroids

(6) A large number of cases have been observed in recent years showing the dangers of giving steroids

to people with latent tuberculosis. We have seen several patients in whom we thought that this was responsible for their developing disease. It is thought to be much more dangerous if the person is under exposure or if he has recently developed an active primary tuberculosis. There have been several cases in the past years in which tuberculosis developed among persons being treated for leukemia or rheumatoid arthritis with steroids.

Pregnancy

(7) Women who are pregnant have been assumed to be more likely susceptible to developing clinical active tuberculosis than is the normal woman. Some feel that this association may be due in part, if not entirely, to the fact that skin tests in these patients may sometimes become negative during pregnancy.

Increase in Age

(8) The general incidence data for tuberculosis suggests that an increase in age means also an increase in the risk of developing adult type tuberculosis. Frost showed many years ago that the risk of developing tuberculosis in later life is associated primarily with the experience of the individual in earlier life indicating the importance of the latent lesion.

Effect on Latent Tuberculosis

Following the studies in children and in contacts which showed such dramatic effects from prophylaxis, the Public Health Service designed controlled trials to test effectiveness of isoniazid in persons with latent tuberculosis and in those with visible lesions which were considered likely to become active lesions. The first trials were for patients in mental hospitals.

We should remember that these persons were living in an environment in which they were protected against infection. All of them had been X-rayed upon admission to the institution and all of them had regular screening examinations thereafter. All of the institutions had the same policy of removal of any person with active or suspected disease from the regular wards to special treatment wards. All the institutions screened their employees to eliminate sources of infections. These persons then, for all practical purposes, could be said to be free of exposure to active tuberculosis, and any disease which developed among them would be endogenous in origin.

Results

At the end of one year, there were 20 active cases among the placebo group, as compared with four among a similar group of the same size who took isoniazid. Follow-up studies in this population group indicate that the effects of isoniazid continued to be manifest, in that the new cases of tuberculosis in the placebo group are three times as great as those in the isoniazid group.

Patients With Apical Fibrotic Lesions

Another group of individuals studied have been those patients with so-called apical fibrotic lesions. These were persons who have more than minimal residuals of primary tuberculosis, and by minimal residuals we mean primarily Simon foci. This group of patients has actual fibrotic lesions, some of which were extensive enough to have been called moderately advanced disease had they been active. None of them, however, had any evidence of activity that could be discovered, such as positive sputum or change in X-rays. These individuals had a very high attack rate in the placebo group, averaging 60 cases per 1,000 per year. This is actually more than twice the rate that would be expected among new contacts. This rate, however, was reduced to 26, which is an overall reduction of more than 55 per cent.

Other studies indicate that the greatest reduction in new cases can be expected in those individuals with a large skin test, as contrasted with those with a small reaction. The reduction among the individuals whose initial tuberculin reaction was more than 10 mm was 60 per cent, whereas it was only 29 per cent in the group who had a reaction between 5 and 9 mms.

The overall effectiveness of prophylaxis has also been demonstrated in other groups such as Alaskan natives and controlled studies carried out in other countries. Children, contacts and adults with positive tuberculin reactions, however, are the group which will be seen by the practicing physician and it is to this group that we wish to direct attention primarily.

Only Two Contraindications

The next question that addresses itself to us is that of what contraindications exist for the use of drugs. Insofar as we have been able to determine, there are only two contraindications for the use of isoniazid as prophylactic agent in dosages of 4 to 6 mgm per kilo. Our personal experience, as well as that of others, indicates that the drug is ineffective when taken irregularly. There seems to be no question that the majority of the prophylaxis failures are associated with irregular pill taking. On the other hand, we must remember that even when isoniazid was first used as a therapeutic agent, there were a significant number of individuals who showed drug resistance at that time, indicating that there were

isoniazid resistant strains of organisms which existed before the drug was ever introduced.

Development of Drug Resistance

The second reason is associated with the question of drug resistance. If the drug is taken irregularly, we can not expect it to be effective, and we might also expect the development of drug resistant strains of organisms if it is taken by an individual whose organisms are in an active growth phase. If the drug is ineffective when taken irregularly, we certainly cannot expect it to reduce incidence of new cases and if it does, at the same time, cause the organism to develop a resistance to isoniazid, then in case the individual does become ill with tuberculosis, isoniazid will be ineffective as a treatment agent. He will therefore have lost his best chance of recovery from tuberculosis because isoniazid undoubtedly is the best agent which we have for treatment of tuberculosis.

Up to this point we have mentioned situations in which patients have indications for prophylaxis which were based on factors other than that of a positive skin test alone. If the patient has no indication for prophylaxis other than a positive tuberculin reaction, we are reluctant to administer prophylaxis to those individuals whose reaction shows less than 15 mms of induration to a 5 unit dose of PPD-S or the same size reaction to a dose of 0.02 mgm old tuberculin. If the person is debilitated and if he has been known to have been exposed to an active case or to have previously had a larger reaction, we do administer drugs to patients with less than 15 mm induration.

Management During Treatment

This brings up the question of management during the prophylaxis period. In the first place, the doctor must be personally convinced that the patient needs prophylaxis. If he is not thoroughly convinced, then it is quite hard for him to advise it in a manner that will impress its importance on his patient. If the doctor is convinced, he should, by all means, spend a reasonable amount of time in his interpretation of the needs for prophylaxis to the patient. Once a patient has understood this need, it is usually adequate motivation for him to start and continue therapy.

We make it a practice to strongly urge the patient never to start therapy unless he is completely and absolutely convinced that he needs it and that he plans to continue through the full course.

The question may arise as to whether the drug should be given in single dose or in divided dosages, and it probably makes no difference. I think it becomes a matter of the patient making a decision of whether he can remember best to take the drug once a day or in three divided doses. The optimum time has not been determined, and it will take considerable additional study to do this. We believe, though, that the minimum time should be one year, although we have seen recent converters revert their tuberculin test within a period of six months.

Few Significant Drug Reactions

Significant drug reactions are going to be quite low, although they will be greater in adults than they are in children, and they appear to be greater now than when we first began using isoniazid in 1952. Individual drug idiosyncracies are something which should contraindicate any administration of the drug unless the individual be desensitized. Since this is not completely and entirely satisfactory, we doubt that it should ordinarily be attempted other than for therapy. The majority of the reactions will be in the form of drug allergies, such as gastrointestinal reactions, headaches and other vague complaints. We have had no serious reactions and we have not hesitated to take the patient off the drug and restart it at least once or twice to see if the same symptoms reappeared.

Yearly Tuberculin Tests

Each patient should have a tuberculin test of course before the treatment is started and we think he should have repeated tests at 12-months intervals for several years. Serial X-ray examinations are essential, and sofar as we know, they should be maintained indefinitely, or at least until such time as it has been determined that the risk has been reduced to such a degree that the X-ray examination is not needed.

The fact that an individual has been found to have a positive skin test is probably adequate reason to suggest that other members in the family also have skin tests. This will certainly turn up other reactors in many instances, and occasionally other skin tests and X-rays in the family will reveal a previously unsuspected source of infection. Recent work reported in the Navy also indicates that they believe that recent converters have positive sputums during the conversion phase and may be sources of further infection. We have serious doubt that this is of clinical significance and for this reason we have not suggested sputum cultures for these converters.

Conclusions

In conclusion I would urge the systematic and discriminate use of the tuberculin skin test. The test is easy to administer and interpret and can be the first, and most important, step toward the prevention of a future illness of major proportions.

The complications with the correct use of this technique have been rare.

Specific Techniques in the Treatment of Diabetic Retinopathy by Light Coagulation

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PROLIFERATIVE DIABETIC retinopathy is rapidly becoming the leading contender as the main cause of blindness in the Western world. It is perhaps already the chief cause of intractable blindness. The solution to this problem would be in finding a cure for diabetes mellitus itself.

Since this does not appear to be in the offing, the responsibility of the ocular complication rests upon the ophthalmologist to seek other modes of therapy to forestall the onset of blindness. Ablation of the pituitary gland has been proposed and appears to be effective in some cases. However, if it were completely effective, it would still leave the large majority of patients untreatable by this technique, because of other medical reasons.

Stops Recurring Hemorrhage

In the past 13 years much has been written regarding the use of light coagulation in the treatment of proliferative diabetic retinopathy. The indications at the inception of this treatment were primarily for stopping the recurring hemorrhage into the vitreous. Since this hemorrhaging often occurred in multiple areas in the eye, it was necessary to treat many areas. With increasing treatment and intensity of treatment, it was soon learned that not only could the localized hemorrhaging be stopped, but there was also an artificially induced remission of the disease. This was manifest by rapid lessening of vascular congestion, clearing of exudates, disappearance of retinal edema and cessation of new vessel formation.

After longer observation it was noted that this was not a permanent remission, but that in many cases there were further regional exacerbations of the disease. The most striking observation was that those patients who were treated in the early stages of the disease did not develop the advanced fulminating proliferative type of disease.

Most patients, however, are not seen in the early stages of the disease and because of the relatively late macular involvement in most cases, there is no forewarning of the impending danger. A great majority of these patients when first seen by the ophthalmologist have involvement of the optic disc, and the para-macular region. It is the purpose of this paper to discuss the treatment of these specific areas.

The techniques, equipment, complications, etc. have been discussed elsewhere. In the past three years, 5 cc. of 10 per cent sodium fluorescein solution have been injected intravenously immediately before treatment. This has been shown to increase the heat absorption in the blue-green range of the spectrum, and it is felt to be an advantage in selectively treating the aberrant structures.

Problem of Proliferative Tissue

Rete formation can be completely obliterated, leaking vessels can be sealed, hard exudates in the retina will disappear, and the retinal edema will vanish with lessening of vascular congestion as the so-called involutional phase of the disease appears.

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Certain problems, however, remain. The main one is the occurrence of proliferative tissue arising from the optic disc.

There has been a great deal of understandable reluctance to treat structures in the proximity of the optic disc and the macula for fear of harming the vital structures in these areas. There also has been a natural reluctance to treat structures within the vitreous, such as proliferative tissue or blood for fear of further shrinkage of the vitreous and thus perhaps producing a retinal detachment. In our experience neither of these fears has materialized to produce these anticipated complications.

Responds Well in Early Phase

In the early phase, before the proliferative tissue on the disc has projected far into the vitreous it can easily be obliterated by light coagulation, following the use of intravenous fluorescein injection. This can be done without jeopardy to the nerve or to the nerve fiber bundles, as demonstrated by perimetry.

Characteristically this proliferation is confined to the nasal aspect of the disc and follows the main vascular arcades eventually encircling the macular region in a pincer-like meshwork. This new vascular structure continues to break down and bleed into the vitreous and eventually encroaches upon the macula. Fortunately, as a rule, the macular region is the last to be involved in this process. Therefore, every attempt is made to preserve this vital area, even at the expense of other not so vital structures in the eye. A great amount of other retinal tissue may be destroyed, providing the areas are not confluent, without great impairment of the visual field.

In many cases after repeated treatment, the proliferative tissue projecting into the vitreous can be destroyed and rendered avascular by this technique, and the disease will go into a phase of involution.

Breaking Up Blood in the Vitreous

We have also attempted to break up blood in the vitreous by this method. When the blood is not too dense, localized areas of pooling of fluorescein may be seen in the vitreous and the treatment is then directed toward these areas. After the light coagulation has been applied directly to this green accumulation, the meshwork of the vascular system in the retinitis proliferans may often be seen. There may also be an actual breaking up of the blood cells within the vitreous as a result of the absorption of the heat by the green staining areas in the vitreous. Often there is a dramatic clearing immediately at the time of the treatment.

Limiting Retinal Detachment

Periodically isolated retinal detachment, not associated with holes, may be seen, and when progressive, such a detachment may often be delimited from spreading by light coagulation.

Evaluation Is Difficult

Evaluating the efficacy of this treatment is most difficult. Valid controls are difficult to establish and the observations and language of the various operators are dissimilar. The argument may be developed that the cause of visual loss in diabetes is due to hemorrhage into the vitreous, hemorrhage into the retina, formation of exudates, growth of proliferative tissue, and detachment of the retina. If this may be forestalled by the use of light coagulation, then it must be assumed that this treatment is of value.

The complications of this technique have been rare and they include hemorrhage at the treatment site, macular burn, detached retina, and keratitis.

Summary

In summary, it may be said that until the metabolic disease of diabetes mellitus is cured, the best treatment at the present time for the ocular complications of retinopathy is light coagulation. It is the responsibility of the internists and ophthalmologists to examine the ocular fundus with the pupil widely dilated at frequent intervals. When the disease is recognized in the early stages it should be treated.

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Colorado Springs Eye Clinic

ELECTION HANDBOOK AVAILABLE

The 1968 Convention and Election Handbook, compiled by the National Research Bureau, Inc., was created to answer the questions of public-spirited citizens. This guidebook covers the major political issues: Democratic and Republican contenders for the presidential and vice-presidential nominations; facts and information about the presidency; party histories and campaign promises; voting information; convention and election tally sheets; and many other valuable features.

Single copies of this 48-page, illustrated handbook may be obtained by sending 25 cents and a self-addressed stamped envelope to Lou Lauth, Jr., National Research Bureau, Inc., 215 South Third St., Burlington, Iowa 52601.

This frequently encountered problem is reviewed in the light of our newer knowledge.

Emergency Treatment of Acute Pulmonary Edema

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ACUTE PULMONARY EDEMA is a common, dramatic and often catastrophic event in the life history of the cardiac patient. It is primarily an expression of disease of the left side of the heart and is therefore seen in patients with acute myocardial infarction, mitral valve disease, especially mitral stenosis, aortic stenosis, aortic regurgitation, severe hypertension, and occasionally in individuals with rapid tachycardias or pulmonary embolism. Rarer types of pulmonary edema include high altitude pulmonary edema, pulmonary edema following drowning or exposure to noxious gases, and that associated with acute renal insufficiency with overhydration. On rare occasions pulmonary edema has been associated with neurological disease including trauma and intracerebral hemorrhage.

Cornerstones of Treatment

In the previously untreated patient, the cornerstones of treatment of acute pulmonary edema are:

(1) sedation, usually with morphine;

(2) improvement of myocardial function by digitalization;

(3) onset of rapid diuresis with the newer diuretic agents;

(4) decreasing venous return and right ventricular output;

(5) removal of precipitating and aggravating factors such as tachy-arrhythmias, paroxysmal hypertension, arterial hypoxemia, metabolic or respiratory acidosis, and increased work of breathing;

(6) proper positioning of the patient.

The above therapeutic measures are most often used concurrently rather than consecutively, especially if the pulmonary edema is severe. Formerly, discussion often centered about the concept whether morphine or digitalis was the most important form of therapy in acute pulmonary edema. The development of the newer diuretic agents such as ethacrynic acid and furosemide has added another primary form of treatment for this condition. Generally, all three agents are administered early in the course of therapy for severe pulmonary edema, in addition to placing the patient in the upright position unless shock is present.

Morphine Therapy

Morphine is best injected intravenously over a two to three minute interval in a dose of 8-10 mg. If necessary, an additional 5-10 mg. may be given one-half hour later. In mild cases the drug may be given subcutaneously or intramuscularly.

Morphine therapy alone will often terminate the

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mild case of pulmonary edema. If respiratory depression results from morphine administration, nalorphine hydrochloride (Nalline) should be given intravenously in 5 mg. doses which may be repeated once or twice at 20-30 minute intervals.

Morphine should be avoided in patients with a history of allergic asthma or chronic pulmonary disease, especially if the arterial carbon dioxide tension (pCO_2) exceeds 45-48 mm Hg. Pulmonary edema in patients with cerebrovascular trauma or accidents should also be treated without morphine. Morphine therapy may result in varying degrees of hypotension which may in turn require therapy.

Use of Digitalis

Improvement of myocardial contractility by digitalis is a second foundation of therapy. Intravenous therapy is generally advisable. If the situation is extremely grave and if the physician is experienced in the use of ouabain, 0.5 mg. of this glycoside is given by vein and followed by further doses of 0.1 mg. every half hour to a maximum of 0.8-1.0 mg. or until clinical improvement is noted. One must be certain that the patient has *not* been receiving digitalis therapy for at least two and preferably three weeks if intravenous digitalis preparations are employed.

Much more frequently lanatoside C or digoxin is utilized for rapid intravenous digitalization of patients in pulmonary edema. The time of onset of action of these latter two agents is less than one hour when given intravenously. If digoxin is utilized, 1.0 mg. is given intravenously, followed by one or two 0.25 mg. doses if needed. Maintenance therapy with oral or intramuscular digoxin may then be employed.

Rapidly Acting Diuretic Agents

The development of rapidly acting diuretic agents —ethacrynic acid and furosemide—has altered the therapy of acute pulmonary edema. The use of 1-2 ml. of a mercurial diuretic intravenously was formerly advocated, but since the onset of a diuresis was delayed for four to six hours, the issue was usually decided before an effective diuresis ensued.

However, administration of either ethacrynic acid or furosemide results in much more rapid diuresis. Both agents when given intravenously produce the onset of diuresis within 15-20 minutes. A liter of urine will often be produced within 60-90 minutes. Oral administration produces onset of diuresis within 60-90 minutes. Ethacrynic acid is given in doses of 50-100 mg. intravenously in pulmonary edema. Oral therapy (100 mg.) is less desirable for therapy of pulmonary edema. Furosemide has not as yet been released for intravenous administration but is available for oral use.

Theophylline derivatives such as aminophylline (0.24-0.48 G in 20 mil. of solution and given slowly intravenously) are advocated by some clinicians, but this observer has seen little evidence of a beneficial effect, unless severe bronchospasm complicates the picture of pulmonary edema. Similarly, surface tension reducing agents such as ethyl alcohol have not been of significant benefit in our hands.

Decreasing Venous Return

Measures to decrease venous return are employed, especially when the above approaches are not effective or only partially effective. The primary measures in this category include rotating tourniquets and phlebotomy. Phlebotomy is accomplished by removal of 500 ml. of blood as rapidly as possible. Positive pressure breathing may also be employed to decrease venous return. Blood pressure must be watched carefully during positive pressure breathing to prevent serious hypotension.

Other measures to decrease venous return, such as spinal anesthesia and stellate ganglion blockade, have been suggested to decrease venous return, but have seen limited use. Ganglionic blocking and sympatholytic agents such as mecamylamine (1-3 mg. diluted in 50 ml. of 5 per cent glucose in water and given slowly intravenously), hexamethonium, dibenamine, and dihydroergokryptine have been employed but experience has been limited. The one situation in which these agents may be useful is in the treatment of pulmonary edema in patients with severe systemic hypertension.

Removing Precipitating Factors

The last category of therapeutic measures embodies the removal of precipitating factors. These include the correction of arrhythmias with rapid or slow ventricular rates. Arterial blood gas analysis has become an essential aspect of therapy in patients in pulmonary edema who do not readily respond to treatment. The most common acid-base abnormality detected is respiratory alkalosis which does not require specific therapy. Decreased peripheral perfusion due to low cardiac output is often a cause of metabolic acidosis, which requires correction with intravenous sodium bicarbonate.

Occasionally, endotracheal intubation or tracheostomy are required for adequate carbon dioxide exchange. Correction of arterial hypoxemia is accomplished by inhalation of high oxygen mixtures and correction of the pulmonary edema. The role of hyperbaric chambers in correction of arterial oxygen unsaturation remains for future study. Surgical correction of aortic and mitral valve disease may be

needed to prevent recurrent pulmonary edema. The final precipitating factors of pulmonary edema that may readily be dealt with involve restriction of activity and prevention of excessive sodium intake.

Utilization of one of the varied types of assisted circulation such as veno-arterial shunting, left heart bypass or counterpulsation offers future promise for the therapy of patients with non-responsive pulmonary edema, but the clinical value and role of these methods have not yet been determined. On the other hand, peritoneal dialysis with hypertonic glucose solution offers a more immediately available palliative procedure for a few selected patients with non-responsive continual pulmonary edema.

SAFE DRIVING HABITS CAN LOWER INSURANCE COSTS

The business of automobile insurance has enjoyed unprecedented "stardom" in recent years. This "stardom" has taken the form of White House inquiries, congressional investigations, and large volumes of complaints that come into State Insurance Departments across the nation.

It is an easy matter for us to "cuss" companies when rates are increased, or consider Federal regulation when we have a complaint with this industry, but we must take time and think about the causes of our discontent with this specific industry system.

The problems we face with automobile insurance require the understanding, cooperation and support of the public in defining solution. Simply stated, the cost of automobile insurance is geared almost totally to automobile accidents.

Related to Highway Toll

This means that our problems today in this field are a result of the consistent annual increases in the number and intensity of wrecks on Georgia highways. The reverberations which echo from these accidents are medical expenses; hospital bills; the price of steel, rubber, and petroleum; the numbers of people involved in law enforcement; designs of highways; labor statistics and hundreds of other factors involved in the cost of automobile repair and automobile manufacturing. All of these things influence the cost of auto accidents and ultimately the cost of the automobiles themselves.

All of us from the Insurance Commissioner down through the ranks of the industry itself are concerned with the problems of cancelled insurance contracts. The blame for these cancelled contracts cannot be placed entirely on the insurance industry.

Quasi-Police Officers

In earlier years, the industry was fully justified in restricting their coverage to individuals who repeatedly had accidents—who were historically reckless drivers. By the very fact that these people were licensed to drive and own cars, they bought insurance. Had they been forbidden by law to drive, they would not have needed insurance. The insurance industry has been forced to be a sort of a "cop" by restricting coverage or refusing it to individuals they judged to be unfit to drive.

The companies, however, sometimes carried this "quasi-police officer" role to extremes when they went beyond cancelling contracts for individuals and began arbitrarily cancelling whole groups. Legitimate companies and the State Insurance Department are now moving forward to discipline the insurance industry and re-open insurance markets for the teen-agers, senior citizens, and many other almost "blackballed" groups. This trend is most encouraging.

Education Is the Key

Inevitably, the solution to problems of the rising cost of automobile insurance is a simple one—safe driving habits by everyone. This, of course, is easy to say, but difficult to enact. We need driver training programs for the young people; adults should take the eight-hour Defensive Driving Course, and law enforcement officials must enforce the law strictly. It is a known fact that people drive more carefully if they know they are being watched. We also have a responsibility to see that our highways and streets are in good condition and to support safe driving legislation.

Every person in this State has an important stake in traffic safety. We must accept this responsibility and cooperate with law enforcement officials who force, train and educate us to drive safely.

James L. Bentley,
State Insurance Commissioner

PEDIATRICIANS CONVENE FOR ANNUAL MEETING

Infectious mononucleosis—new developments, the current status of organ transplantation, sex education —the parent's role, pediatric aspects of cigarette smoking, the sudden death syndrome, and drug use and abuse in adolescence will be among the subjects examined during the 37th annual meeting of the American Academy of Pediatrics in Chicago, October 19-24.

More than 4,500 persons including pediatricians, their families and guests are expected to attend the meeting in the Palmer House Hotel.

This condition is easy to diagnose and is amenable to local therapy, but prevention is complicated by the complexity of our technology, inadequate labeling, and poor communication between the practicing physician and plant management.

Occupational Dermatitis From Plastics

MARCUS M. KEY, M.D.,* ***Cincinnati, Ohio***

A RAPID SCRATCH REFLEX in response to itching may have had survival value in man's evolutionary development—favoring the person who responded quickly to the bite of a mite, louse, or bed bug. We no longer have these classic causes of itching with us, but we still have with us the $200,000,000 itch known as occupational dermatitis. Unfortunately the lag or reaction time from exposure to onset of itching in occupational dermatitis is measured in hours or days, which is too long for itching to have any warning value. Instead we must rely on education, hygiene, and engineering controls. The causes and prevention of occupational dermatitis are conveniently illustrated by examples from the manufacture and application of plastics and resins.

Classification of Plastics

Plastics were so named because they can be shaped into almost any form. For thermoplastics, this property can be produced repeatedly by the application of heat and/or pressure, but with thermosets, the desired shape can be produced only once, as they cure or harden with the addition or production of heat. Synthetic resins or resinoids, from which some plastics are made, were named from their resemblance to natural resins. Plastics is a term preferable to resins when speaking of the group as a whole, but resin is preferred when speaking of a plastic made from a resin-like material, e.g., epoxy resin.

Besides the classification of plastics into thermoplastics and thermosets, and into family groups based on their chemical composition, they can also be classified as addition polymers and condensate polymers. The former are made by the addition of a large number of identical molecules, called monomers, into a long chain (illustrated by polyvinyl chloride). The latter are made by the combination of a number of molecules, not necessarily of the same composition, with the liberation of water, carbon dioxide, or other simple substance (illustrated by the condensation of bisphenol and epichlorohydrin to form an epoxy resin).

No Dermatitis From End Product

The chemical spectrum of plastics seems to be without limit, yet there is practically no dermatitis from the end product, which is usually completely cured or polymerized. Most of the industrial dermatitis that occurs, occurs in the curing or hardening of several thermosetting resins, notably phenolics, aminos, epoxies, and polyesters.

The dermatitis associated with the manufacture or application of plastics and resins is caused by monomers, low molecular weight polymers, condensate components, fillers, and also by other chemicals which are added for various reasons, such as cross-linking agents, catalysts, accelerators, plasticizers, and solvents. The dermatitis produced by working with the various plastics and resins is similar in appearance, differing only in acuteness and location.

The acute stage, manifested by erythema, edema, and vesicles, and accompanied by pruritis, can be

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Presented before the Georgia Society of Dermatology, May 5, 1968.
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caused by either irritating chemicals or sensitizers. The chronic stage, which is the end result of repeated acute attacks or the result of exposure to low-grade irritants such as solvents or harsh cleaners, has a dry, scaly, fissured, and lichenified appearance and is also pruritic.

Patch Test

The skin is limited in the ways it can react, and it is almost impossible to distinguish clinically between irritant contact dermatitis and allergic contact dermatitis. This is why occupational dermatologists frequently make use of the patch test, which attempts to reproduce allergic contact dermatitis at the site of application of the suspected chemical in a non-irritating dilution.

As mentioned above, there are four troublesome family groups of plastics which are associated with occupational dermatitis—phenolics, aminos, epoxies, and polyesters—the subject matter of this presentation. In addition, attention will be called to two other family groups, the polyvinyls and polyurethanes, which recently have been implicated in some unusual hazards.

Formaldehyde Resins

The phenolics and aminos can be considered together as formaldehyde resins. The oldest of these is phenol-formaldehyde resin or "Bakelite," developed in America in 1909 by Baekeland. The most recent use of phenolics has been as an ablation-type heat shield for reentry vehicles. Substituting cashew nut shell liquid (which has many hydroxyl groups) for phenol produces cashew nut shell liquid-formaldehyde resin, from which automotive brake shoe linings are made. Substituting urea, melamine, or similar chemicals produces the amino resins, which are used similarly to the phenolics as wood glues, laminates, and molding materials. The aminos have long been used as textile finishes, but the recent development of durable press clothing has greatly increased their demand.

Dermatitis produced from contact with formaldehyde resins, illustrated by plywood glue dermatitis and by dermatitis from fabric finish in a "lace tenter," may be irritant or allergic, caused by the phenolic or amino component, formaldehyde, or an intermediate reaction product.[1, 2] Hexamethylenetetramine, a formaldehyde liberator, used as a stabilizer and catalyst, can also cause dermatitis.

For the phenolic and amino resins, there are several degrees of cure, and contact with any except the last is potentially, but not always, dangerous. For example, in the manufacture of durable press garments, cutters and sewers handle the fabrics and are intimately exposed to the resin in an uncured state. Formaldehyde, liberated from the resin treated cloth, irritates the eyes, nose, and throat when ventilation is inadequate, but the garment workers rarely develop dermatitis. Complete curing is achieved only during the final pressing and heating operations, and in this stage the resin is not hazardous. A rare exception is allergic contact dermatitis from formaldehyde in the finished garment.[3]

Epoxy Resin Systems

Epoxy resin systems have caused more occupational dermatitis in recent years than any other single industrial material.[4] They were developed in the early 40's by Ciba in Switzerland and about the same time by Devoe and Reynolds in the United States. The Swiss were several years ahead of the United States in production of epoxies and also in recognizing the related dermatitis.

Production in the United States began in 1947, and has reached about 100 million pounds. The name is derived from epoxide linkages. The long chain compounds, originally made from the condensation reaction between bisphenol A and epichlorohydrin, more recently are derived from epoxidizing polyolefins. Curing or hardening agents (amines, amides, anhydrides) cross-link the chains at epoxide and hydroxyl groups and produce three dimensional stability.

Epoxies have seen wide use as adhesives and bonding agents, casting and potting materials, fibrous glass reinforced laminates, and resistant coatings. Their use in constructing the restaurant in the eye of the needle at the Seattle World's Fair and in making terrazzo floors gave them a bad reputation among the construction unions because of the high incidence of dermatitis among workers. As high as 40 per cent of exposed workers have developed dermatitis, much of which was allergic in nature.

The dermatitis potential of epoxy resin systems is summarized in Table I. Unprotected mixing and use results in irritant contact dermatitis (illustrated by dermatitis on the wrist of a chemist where he was splashed with an epoxy resin) and in allergic contact dermatitis (illustrated by dermatitis on the face and arm of a worker exposed to a volatile aliphatic amine). Metaphenylenediamine, an aromatic amine hardener, stains exposed skin a brownish color, not unlike its cousin paraphenylenediamine, a hair and leather dye. There has been an exemplary attempt within the plastics industry to classify the toxic properties and local action of epoxy resin systems and to establish standard precautionary measures.

Polyester Resins

Polyester resin production, now over 250 million pounds annually, began early in World War II, stimulated by applications in the aircraft industry—aircraft glazing, protective shields for self-sealing gas tanks, and radar housings. Fibrous glass reinforced polyester resins are molded in a number of ways—by hand lay-up, spray-up, or by matched metal die molding. Examples of application include boat hulls, sports car bodies, automotive body putty, chairs, safety helmets, and decorative translucent panels.

One of the early classifications for polyesters gives a clue to their chemistry—alkyd (derived from ALcohol and aCID, the reaction product of which is an ester). Polyester resins are frequently modified with styrene, which acts as a cross-linking agent. Dermatitis may result from contact with the polyester resin, styrene, organic peroxide catalysts, plasticizers, or accelerators and may be due to irritation or sensitization. Fibrous glass spicules embedded in the skin cause an inordinate amount of itching, and most of the dermatitis produced from this exposure is caused by scratching. Solvents are responsible for much of the dermatitis seen in polyester fabrication. Styrene and ketone solvents produce the typical picture of chronic contact dermatitis—dry, scaly, fissured, and lichenified skin.[5]

Polyvinyls

Compared with the preceding plastics, the polyvinyls have a good reputation, and even the manufacture of this plastic was thought to be safe. The few cases of dermatitis that have been reported were caused by sensitivity to a plasticizer in the vinyl.[6] However, recently acroosteolysis, or loss of bone in the tips of the fingers, was observed in polycleaners—workmen who clean hardened polyvinyl chloride from reaction kettles. It was first seen about 1964 and has occurred in several factories in the United States and Europe. Raynaud's phenomenon and a plaque-like thickening of the skin are sometimes associated with acroosteolysis. Cause is unknown, but exposure to the vinyl chloride monomer or to a peroxy-compound is suspected. The acroosteolysis is usually reversible if detected early.[7, 8]

Polyurethanes

The polyurethanes (isocyanate resins) are the newest of the plastics. Isocyanate monomers are irritating to the skin, but because of precautions taken to prevent respiratory tract irritation and sensitization, there has been very little dermatitis from the manufacture and spraying of polyurethanes.[9] Cutaneous sensitivity to toluene diisocyanate (TDI) has been reported in workmen protected by air-line respirators, but is rare.[10] Aliphatic amines and organic tin compounds, used as catalysts, are strong primary irritants but are diluted in the foam mix and are not as irritating as TDI. If the hot reacting foam gets on the skin, it can cause an irritant dermatitis, and the solvents (methylene chloride, methyl chloroform, or dimethylformamide) used to clean guns and lines can also irritate the skin. Except for rare sensitization to spandex[11] a polyurethane elastomar, the finished product is innocuous.

One of the isocyanates, methylene diphenyl diisocyanate (MDI), has been associated with an unusual soiling of the hands among foundrymen using a new no-bake binder. The other components are an air-curing oil such as linseed oil and a metal-drier catalyst such as cobalt naphthenate. The isocyanate cross-links the oil and provides sufficient strength to permit stripping and handling prior to air curing, but it also binds dirt and graphite so firmly to the hands that cleaning is almost impossible.[12]

Prevention of dermatitis can be achieved by environmental methods and personal methods. Substitution is high on the list of environmental methods, but is seldom feasible because product specifications usually take precedence over hygienic considerations. Of the epoxy hardeners available, one, polyamide resin, is worthy of mention because it seldom if ever produces dermatitis.

TABLE I

DERMATITIS POTENTIAL OF EPOXY RESIN COMPONENTS

Primary Irritation	Components	Sensitization
Inversely proportional to molecular weight	Uncured liquid epoxy resins	Uncommon
Rare	Uncured solid epoxy resins	Rare
Common	Reactive diluents	Uncommon
Common	Amine hardeners	Common
Uncommon	Anhydride hardeners	Rare
None	Polyamide resin hardener	None
None	Cured epoxy resins	None
Common	Fibrous glass	None
Common	Solvents (ketones, esters, ethers)	Rare

Contact Can Be Minimized

In manufacturing items from plastics and resins, enclosure of the process is seldom practicable, but the process usually can be isolated as in a resin-mixing booth. Exhaust ventilation can be provided at the booth or at imbedding and encapsulating machines. Push-pull ventilation is helpful in controlling fibrous glass dust generated by sanding fibrous glass reinforced plastics. Alternately, housing and a vacuum cleaner line can be attached to sanders and routers. Proportional pump mixers dispense the correct amount of hardener for a given amount of resin, and paper containers minimize clean-up. Good housekeeping is important, not only in minimizing contact, but also in inspiring the workers to be cleaner.

Protective Clothing and Ointments

Of the personal methods which are available, protective clothing is the safest. Care must be taken in selection of gloves and apron which are not adversely affected by the resins and solvents. Protective ointments have their place for those workers who cannot or will not wear gloves; their use insures a certain amount of hand washing, but protective ointments are of little value after sensitization has occurred. Soap and water wash-up is seldom sufficient to remove tenacious resin soils. Sparing use of solvent on a cloth or a mixture of equal parts of acetone and sulfonated oil is helpful in removing resins, but this should be followed by soap and water washing. Many resin shops now supply an emollient for use after water washing to minimize drying and chapping in the winter time.

Of further help in preventing occupational skin diseases would be a labeling law for industrial chemicals and upgrading of State and local occupational health agencies. Industrial hygienists and physicians in these agencies can help in improving communications between the practicing physician and plant management.

In spite of preventive measures and constant vigilance, there will still be a few cases of occupational dermatitis. The combination of forgetfulness, familiarity, and ingenuity in circumventing controls is almost unbeatable. However, even in defeat there may be some recompense. There is a certain amount of pleasure associated with the ability to scratch, and this gratification is so intense that some individuals overscratch with a vehemence that amounts to passion. Ogden Nash summed it up very nicely as follows:

One bliss for which
There is no match
Is when you itch
To up and scratch.

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The technique of choice must be decided on the basis of age, sex, occupation, and available tissue.

Reconstruction of the Thumb

WALDO E. FLOYD, JR., M.D., *Macon*

A HAND WITHOUT A THUMB is no hand at all, but four fingers which are markedly limited in function. The hand, normally, can carry out three basic functions—hook, pinch and grasp. A hand with its thumb amputated is severely limited in both pinch and grasp. It requires the other hand to pick up and hold objects. A short stiff thumb can be a useful digit. It must be fixed in a position where the other fingers can oppose it, or be able to move into this position by muscle or tendon pull. A thumb must be stable, either by muscle or tendon action or by bony fusion. It needs good skin with adequate, underlying aerolar tissue. A painful or anesthetic thumb will not be used.

Useful Thumb Must Move

In order to oppose the other fingers, the thumb must be able to move away from the other portion of the hand and the fingers that it is to oppose. The pulp of the fingers and the end of the thumb should meet. The thumb should have some motion in flexion or adduction in order to aid in grasping.

It is often amazing how well a patient will be able to use a short amputated stump where there is good skin coverage and no pain. Good skin coverage and sensation may be acquired by local flap, Z-plasty or a neurovascular pedicle transfer. A good tactile surface can be provided by the "cocked hat" method of Gillies, whereby a dorsal flap of skin is elevated and a bone graft slid under the skin to gain length and a split thickness graft used to cover the donor site. The Mobert procedure, where the volar skin is advanced to cover the thumb end, may be used.

Instability Can Be Restored

Instability of a thumb, by loss of muscle, tendon or bone, can be restored by tendon transfer, arthrodesis or intermetacarpal bone graft. Good soft tissue is necessary for bone grafting. The joints of a thumb may be arthrodesed to each other, or the thumb may be arthrodesed to the second metacarpal. There should always be at least one joint capable of motion in the thumb, or it will be a fixed post, having to be put in the plane of action of the fingers, allowing only pinch, the action being obtained through motion of the fingers.

A thumb that is traumatically or congenitally amputated may be restored to a functional length by one of several methods: (1) local pedicle transfer and bone graft, as the "cocked hat" procedure of Gillies; (2) deepening the web between the index finger and the thumb, or between the amputated thumb and whatever portion of the hand remains; (3) tubed pedicle bone graft and neurovascular island pedicle graft; (4) pollicization procedures and (5) digital transfer from the other hand or foot.

Function and Appearance Are Important

In deciding which method to use in an individual case, the factors of age, handedness, occupational skills and economic loss should be taken into consideration. The function of the hand is the most important thing, but appearance should also concern the surgeon.

Case Report

There is a case of a 24 year-old female who amputated all the fingers and thumb in a meat cutting saw. She had been treated by debridement and closure initially. She had little more than a paddle.

Subsequently, we removed the second and third metacarpal. A local, well innervated pedicle was raised, after the "cocked hat" technique of Gillies.

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A free bone graft from the second metacarpal was grafted to the stump of the thumb metacarpal. A full thickness free graft was utilized to deepen the webspace, after the transverse head of the adductor pollicis had been divided and dissection carried down to the carpometacarpal joint.

Later, the remaining metacarpal phalangeal joint of the fifth finger was immobilized by a capsullectomy. A tendon transfer gave good opposition to the fifth finger post and remaining position of the fourth metacarpal. This patient has good pinch and grasp. She lacked the ability to hook. This was her dominant hand.

Adding Length to a Thumb

Considerable relative length can be added to a thumb by deepening the first cleft. The abductor pollicis and the first interosseus muscle must be stripped down. A deep Z-plasty and a split thickness graft can be used to cover the defect. A sliding flap, according to the Curtis technique, can be brought down from the dorsum of the hand; a split thickness graft covers this donor site. Where there is a very tight contracture, an abdominal pedicle graft is necessary. Where an index finger has been partially amputated or is beyond repair, it is best to remove the entire index finger with its metacarpal, in order to deepen the cleft.

Tube Pedicle Skin Graft

When a thumb is amputated proximal to the metacarpophalangeal joint, it may be lengthened by a tube pedicle skin graft from the abdomen or chest wall. Later a bone graft from the ilium, tibia, fibula, rib or another metacarpal or phalanx may be inserted to give bony stability. This technique was originally reported by Nicoladoni in 1897.

The tube is best attached to the base of the thumb with the seam of the tube dorsal. Three weeks later it is divided and closed. After this soft thumb has been completely healed and has good blood supply without any evidence of infection, a bone graft may be inserted through the seam.

A spike is driven into the remaining metacarpal, trapezium or scaphoid. A Kirschner wire may be used to hold this graft in place. The graft must be put in the correct position of opposition.

In one case, a thumb was lost when a mule balked, while a 13 year-old colored boy was leading him by a rope out of the window of a moving car. An abdominal pedicle flap and *bone* graft was applied.

A corn picker injury was treated by debridement, closure and internal fixation. The thumb developed dry gangrene. At amputation, an abdominal pedicle flap was applied. Later an iliac bone graft was performed. A Z-plasty was performed for webspace contracture. A full thickness flap with sensation was transferred to give a useful thumb. This thumb is at first anesthetic. After many months it will acquire some degree of sensation to light touch and pin prick. It never developes sterognosis.

After developing the tube pedicle and bone graft, a sliding flap can be transposed from the side of the index finger to give better sensation. However, pulp skin gives the best sterognosis, and can be acquired by the use of an island flap taken from another finger. A portion of skin is usually taken from the ring finger pulp and the entire neurovascular pedicle to this skin is kept intact and transferred subcutaneously to the volar ulnar aspect of the thumb. This technique has the advantage over pollicization of retaining all of the other fingers for strength of grasp and at the same time providing a useful thumb.

Transferring a Digit

In 1903, Lushka transposed an index finger to a thumb. However, he cut the digital nerves. It remained for Bunnell in 1929 to transfer a digit making the first reconstructive thumb with both movement and normal sensation.

If a surgeon can be relatively sure that a digit will survive with both movement and normal sensation, he may be justified in pollicizing a normal finger. Frequently, when the thumb is amputated another digit will be deformed and it may be used. The hand will be narrow and grasp will not be as strong. The finger has to be shortened to make a more functional, cosmetically acceptable thumb.

If the middle finger is used, the index finger metacarpal should be moved over to the third metacarpal, in order to widen the thumb cleft and give a more functional hand. The ring and fifth fingers may also be used.

The index finger is most often chosen. It is transferred on a neurovascular pedicle as an island transfer without a skin bridge. If an index finger of normal length is chosen, it will need to be shortened. The bone may be spiked into the carpus or, if a portion of the first metacarpal remains, it can be held by an intramedullary bone peg, using transverse Kirschner wires across each fragment through the peg.

The volar nerves, as well as the digital arteries must be preserved. If possible, a dorsal vein should be preserved for venous return. If a dorsal vein cannot be preserved, it is best to place the cut end of the dorsal veins out through the wound, in order that

the blood may be drained off to prevent edema of the pollicized digit and venous stasis.

The tendon action is best provided by shortening of the tendons or transferring the normal thumb motors to the pollicized digit. If the little finger is used, the intact flexor tendon, nerve, and vessels are transferred to the first ray under the median nerve.

Pollicizing an Index Finger

A young, white male suffered a shotgun blast to his dominant left hand, with complete loss of the thumb, save for the stump of the metacarpal and the tip of the thumb held by the flexor pollicis longus. The wound was thoroughly debrided and closed with a split thickness skin graft. The stump of the metacarpal was preserved. The wound healed without infection.

After lengthy discussion with the patient we decided to pollicize the index finger. Flaps were ele-

Transfer of the left index finger with the neurovascular bundles intact and pedicle flaps to replace the amputated thumb—pollicization of the index finger.

Shotgun blast dominant left hand; twenty-two year-old white male, with loss of the entire thumb and injury to both the median and ulna nerves.

Demonstrates full extension of the pollicized finger and remaining digits.

X-ray of left hand, demonstrating that only the base of the thumb metacarpal remains.

Demonstrates full flexion and the patient making a fist with the pollicized finger.

vated and the index finger with its shortened metacarpal was transferred to the thumb metacarpal stump. It was secured with an intramedullary bone graft. The volar digital nerves and vessels with one dorsal vein were preserved. One small split thickness skin graft was required. The extensor pollicis longus was attached to the extensor digitorum communis of the transferred digit.

Demonstrates opposition of the pollicized finger to the other digits.

Sensation to all fingers, which was diminished after the injury, returned. There is full extension of all digits and good flexion. The pulp of each finger can be touched by the pollicized digit.

Congenital Absence of the Thumb

Usually, when there is congenital absence of the thumb, there is frequently absence of the trapezium and scaphoid. There is some question about the advantage of doing a pollicization procedure when only one thumb is congenitally absent. When both thumbs are absent, it is felt to be more imperative. A short, congenital floating thumb does not usually offer much to work with in reconstruction and is best amputated and pollicization carried out.

Nicoladoni in 1898, first attempted to transfer a finger from the other hand and a toe from the foot. No attention was paid to the nerve supply. The transferred digits soon degenerated because they were stiff and had no sensation. Some people feel that pollicizing the finger narrows the hand. In children, they prefer to do a total thumb transfer, with tendon reconstruction and nerve graft to restore maximum function. A long period of treatment is necessary with fixation of the hand to the foot from four to six months. The first and second toes are most often used. This operation is rarely used, except in children with severely disabling congenital deficiencies.

Conclusion

In summary, it should be remembered that each case has to be decided on its individual merit and which technique to use must be decided on the basis of age, sex, occupation and available tissue. Function is always of prime importance, but appearance must not be left unattended.

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September 30-October 1—"Hematologic Aspects of Child Care-1968," Medical College of Georgia, Augusta.

October 17-18—Psychiatry in Clinical Practice, Medical College of Georgia, Augusta.

October 28-November 1—Family Practice Symposium, Medical College of Georgia, Augusta.

1969

March 5-7—Selected Topics in Internal Medicine and Dermatology, Medical College of Georgia, Augusta.

March 11-12—Clinical Application of Recent Developments in Obstetrics and Gynecology, Medical College of Georgia, Augusta.

March 18-19—Disorders of the Pituitary Gland, Medical College of Georgia, Augusta.

April 1-3—Changing Concepts in Electrocardiography, Medical College of Georgia, Augusta.

May 4—Pulmonary Disease Seminar, Savannah, Ga.

May 22-23—Immune Responses—Helpful and Harmful, Jekyll Island, Georgia.

GOVERNMENTAL CONTROL

UNFORTUNATELY, MEMBERS of an organization who have an intense interest in its stability, growth and progress are about the only ones who keep up with the main and related activities proposed and expounded by their contemporaries. The rank and file members do not attempt to remain informed. It is therefore encumbent upon the interested ones also to do missionary work with those who are prone to let things take care of themselves.

Information and ideas disseminated in this and other similar periodicals should be discussed with all of our colleagues at frequent intervals. By the same token, a few seconds more with patients in the doctor's office can improve our civic image and at the same time stimulate better community thinking. Governmental control is an area where all doctors should remain aware. In our way of evaluating things it has already gone too far. Admittedly, a certain amount is good and necessary, but when an avalanche gets enough momentum, there is no stopping it short of the bottom depths.

With the coming elections we must give soul-searching thought; we must expound our views; and we must urge all of our patients and friends to exercise their right to vote. It is a privilege—also an obligation. In our MAG it is a privilege and an obligation to remain alert and aware of all things which involve us.

The GAMPAC and AMPAC organizations are well conceived and can serve our purpose to good advantage. Regrettably, the format and activities of these groups are misunderstood by many doctors. Those steering these organizations are not men who wish to dictate political leanings, but to help guide political action in a direction favorable to the retention of our free enterprise system of medical practice as much as possible. I hope that members who are disenchanted with our PAC movements will re-evaluate and back them. Everybody cannot be satisfied in every instance, but I am convinced that the PAC concept is indeed worthwhile.

Charles R. Andrews Jr. M.D.

Charles R. Andrews, Jr., M.D.
President, Medical Association of Georgia

GEORGIA ADOPTION PROCEDURES

JOHN L. MOORE, JR., *Atlanta**

FREQUENT INQUIRIES from physicians indicate the desirability of general discussion here of the laws regulating adoptions in the State of Georgia.

Basic Provisions

To adopt another person the adopting person must be an adult. If unmarried, the foster parent must be at least 25 years of age. If the adopting persons are married, they need only to be 21 years or older and both parents must adopt unless one parent is the natural parent of the child and the other, the step-parent, is adopting, in which case only the step-parent needs to adopt the child. In all cases, the adopting parent or parents must be at least ten years older than the child. In all cases, the adopting parent or parents must be residents of the State of Georgia.

The superior court of the county in which the adopting parents reside has jurisdiction. In some cases the court may take jurisdiction in the county of residence of the child or where the child is in custody of a licensed child placing agency. In some cases the juvenile court may order placement of children.

Upon filing of the petition a hearing is set at least 90 days after the filing of the petition. Service of the petition must be effected on all persons who must consent to the adoption. The natural parents of a child must consent and the child's consent in the presence of the court must also be obtained if the child is over 14 years of age.

Exceptions to Parental Consent

There are exceptions where the natural parent's consent is not required:

(a) Parental consent is not required if the natural parents have abandoned the

* *Prepared at the request of The Medical Association of Georgia. Mr. Moore is a member of the firm of Alston, Miller & Gaines, General Counsel to The Medical Association of Georgia.*

child or if the parent or parents are insane or otherwise incapacitated to give such consent.

(b) Consent is not required if the parents have surrendered the child to a licensed child placing agency, the State Department of Family and Children Services, or where custody of the child has been removed by order of a juvenile or other court of proper jurisdiction.

(c) If the child is illegitimate, only the natural mother's consent is necessary.

(d) If the child has a guardian, the guardian's consent is necessary.

It is specifically provided in Georgia law that the natural parents of the child may consent even though such parents are minors.

Investigation

In every case the clerk of the superior court in which the petition has been filed must send a copy of the petition to the State Department of Family and Children Services within 15 days of its filing. Prior to the hearing on the petition, the State Department or its agent or a licensed child placing agency appointed by it, must verify the statements in the petition and make a complete and thorough investigation of the entire matter, reporting its findings and recommendations to the court. The statute requires the report to contain investigation, answers, and recommendations to the following questions:

(a) Why do the natural parents desire to be relieved of the care, support, and guardianship of the child?

(b) Has control of the child already been relinquished by the natural parents?

(c) Are the proposed foster parents financially able and morally fit to have the custody of the child?

(d) What is the physical and mental condition of the child as determined by competent authority?

(e) Would the adoption be to the best interest of the child?

(f) Is the child suitable to the home proposed, including questions relating to racial and religious affiliation?

(g) Any other information of value to the court is to be supplied.

It is to be emphasized that the laws of Georgia require the investigation and report to be made in every case of adoption of a child.

Hearing

At the final hearing any person related by blood to the child, if the child has no father or mother, may object to the adoption. Since May 1, 1966, Georgia law has not required two hearings. Prior to that date there was an interlocutory hearing after which the investigating agency had to make another investigation and report back to the court. The final hearing was held six months after the interlocutory hearing.

The final hearing is required by law to be held in the judge's chambers and not in open court. Witnesses are examined under oath. The court is to consider the report filed by the investigating agency, if one has been filed. The court, in its discretion, orders adoption if the court is satisfied that the adoption is to the child's best interest, that the natural parents have consented to the adoption, are not alive, or there is other proper statutory reason to remove custody from the natural parents. In addition, the court is to determine that the foster parents are financially able and morally fit to take care of the child and that the child is suitable to the home.

Georgia law also allows for the adoption of adults under a simpler procedure not involving investigations and reports by investigating agencies.

Suite 1220
C & S Bank Building

Rural Health Conference Scheduled for October

THE FOURTH ANNUAL RURAL HEALTH CONFERENCE is scheduled for Friday and Saturday, October 4 and 5 at the Rock Eagle 4-H Center near Eatonton. Jointly sponsored by the MAG Committee on Rural Health and the Georgia Farm Bureau Federation, the 1968 edition is designed to inform registrants of some of the current problems facing rural Georgia.

Dr. Haverty to Speak

The keynote speaker will be J. Rhodes Haverty, M.D., Dean, School of Allied Health Sciences, Georgia State College, Atlanta. Dean Haverty will discuss some of the current as well as projected needs in the area of paramedical manpower.

Other areas of emphasis include: Importance of the School Lunch; Current Status of Rabies in the Southeast; Farm Safety; Common Poisonous Plants; Community Action Workshop; What One Community Has Done Concerning Local Participation; and Traffic Safety.

State and Local Groups Represented

The 1968 program was drafted by the Georgia Rural Health Council which is composed of representatives from Georgia Congress of Parents and Teachers; Georgia Vocational Education; Georgia Safety Council; Georgia Department of Public Health; Georgia Farm Bureau; Georgia Extension Department; and the Medical Association of Georgia.

The two-day Conference will draw approximately 125 persons from all areas of Georgia representative of both State and local rural organizations.

FOURTH NATIONAL CONGRESS ON HEALTH QUACKERY

October 2-3 **The Drake Hotel, Chicago**

Sponsored by the AMA and National Health Council

Inquiries should be addressed to Joseph A. Sabatier, Jr., M.D., Chairman, Committee on Quackery, American Medical Association, 535 North Dearborn Street, Chicago, Illinois, 60610.

SICKLE CELL HEART DISEASE

C. WALKER BEESON, II, M.D., *Augusta*

OF AN ESTIMATED greater than 2,000 Negroes in Georgia with Sickle Cell (SS) Disease, a large percentage will have evidence of heart disease.

The term sickle cell heart disease covers a spectrum of conditions which affect the heart in patients with sickle cell anemia. These conditions can be divided into four general categories: anemic heart disease, pulmonary heart disease, sicklemic cardiomyopathy, and coincident heart disease.

Significant Hemoglobin Level

Severe chronic anemia is invariably associated with heart disease which is generally reversible with correction of the anemia. Its pathophysiology is not completely understood, but is thought to reflect the combination of myocardial hypoxia and increased work load on the heart produced by the anemic state. There are some who consider sickle cell heart disease to be no more than a refractory form of this "heart disease of anemia." However, heart disease with other types of anemia is not usually manifested with hemoglobin levels greater than 5 grams per cent; but in sicklemia, cardiac disease is frequently seen at hemoglobin levels of 7-8 grams per cent.

Sicklemia frequently produces small pulmonary vessel plugging, and obliterative pulmonary endarteritis follows. When this is severe and extensive, pulmonary hypertension and cor pulmonale may supervene. This situation is somewhat analogous to that seen with multiple small pulmonary emboli.

Less well documented, but probably quite frequent in occurrence, is small coronary vessel plugging with subsequent coronary endarteritis. This undoubtedly is a large contributory factor to the picture of the primary myocardial disease seen. Pathologically the sicklemic heart muscle shows changes of myocardial degeneration, focal areas of fibrosis, and obliterative endarteritis. All but the endarteritis can be seen with severe anemia alone.

Sickle cell disease does not protect one from having an additional unrelated coincident heart disease. Although rare, rheumatic heart disease has been well documented in sickle cell anemia.

The combination of sickle cell anemia and rheumatic fever is especially confusing in that the sicklemic crisis can closely mimic an episode of acute rheumatic

Prepared at the request of the Committee on Professional Education of the Georgia Heart Association.

fever. Almost any patient in crisis will satisfy the modified Jones criteria. Helpful points in differentiation are the long bone pain (as well as the joint pain), the poor response to salicylates, and the usually short or normal sedimentation rate (a reflection of the abnormal red cell morphology) seen in sicklemic crisis. Absence of serologic evidence of antecedent streptococcal infection (ASO titer) is strong evidence against diagnosis of acute rheumatic fever.

Most Common Manifestations

The most common manifestations of sickle cell heart disease are cardiomegaly and murmurs. The patient may be asymptomatic or have symptoms ranging from mild dyspnea to overt congestive failure. The cardiomegaly may be slight and only radiographically apparent, or it may be massive. All types of murmurs have been found in the absence of organic valvular disease. Aortic and pulmonic ejection murmurs related to the high cardiac output are most common. Cardiac dilatation may produce murmurs of mitral and tricuspid regurgitation. Increased flow across the mitral and tricuspid valves may create diastolic rumbles. Basilar diastolic murmurs are sometimes heard, but their mechanism often is not clear. Some undoubtedly are pulmonic insufficiency related to acquired pulmonary hypertension. Prominent third heart sounds are common.

There is no specific therapy for sickle cell disease. Unless there is evidence of decompensation, no therapy is indicated for the associated heart disease. In the presence of congestive failure, digitalis should be used, though it may be less effective than in other types of heart failure; and salt restriction and diuretics should be employed.

Medical College of Georgia

"Either we shall master the ways of Political Action, or we shall be mastered by those who do."

JOIN

GAMPAC

ABSTRACTS BY GEORGIA AUTHORS

Sussman, Hy C., M.D., Fowler, Barbara, and Findley, Thomas, M.D., Medical College of Georgia, Augusta, Ga., "Observations on the Renal Metabolism of Protein in Experimental and Clinical Nephrotic Syndromes," Metabolism Clinical and Experimental 17:336-344(April)1968.

To determine the contribution of increased albumin catabolism to the hypoalbuminemia of the nephrotic syndrome, renal arterio-venous differences of albumin, peptide-nitrogen, and alpha amino nitrogen were performed in aminonucleoside treated rats; then kidney and liver slices from these animals were incubated with radioactive albumin. Also patients with hypoalbuminemia due either to renal or liver disease were given radioactive albumin intravenously, and daily specific activity ratios were determined for the trichloroacetic acid soluble and precipitable fractions of their plasma.

The results showed statistically significant differences between nephrotic and control groups of animals and patients, and suggest accelerated protein catabolism in experimental and clinical nephrotic syndromes; however, they do not indicate that other abnormalities of albumin metabolism are not operative or that the defect is specific for renal disease.

Okel, Benjamin B., M.D., Emory University School of Medicine, Atlanta, Georgia, "The Wolff-Parkinson-White Syndrome," Am. Heart J. 75:673-678(May)1968.

The WPW (Wolff-Parkinson-White) syndrome is usually regarded as a benign curiosity, significant only in that a variety of arrhythmias are likely to occur and that a misdiagnosis of myocardial infarction is an easy pitfall. However, the medical literature records at least 22 cases of sudden and unexpected death in these patients.

A case of WPW syndrome with atrial fibrillation resulting in death is presented. Autopsy revealed lipomatous hypertrophy of the interatrial septum, diffuse interstitial myocarditis, and an abnormal muscle bundle within the right ventricular cavity. The last finding suggests a possible etiologic relationship of ventricular pre-excitation to myocardial hypertrophy. Evidence is presented that indicates premature localized ventricular contractions produced by anomalous AV conduction may account for some cases of idiopathic hypertrophic subaortic stenosis.

McLone, David G., M.D., Billings, Terrence E., M.D., Hardegree, William E., Medical Technician, and Hackney, James F., M.D., National Communicable Disease Center, Atlanta, Ga., "Gonorrheal Urethritis in Males Treated with One Oral Dose of Ampicillin," Southern Medical Journal 61:278-280(March)1968.

Because of the increasing resistance of the gonococcus to penicillin, new antimicrobial agents are being investigated. Ampicillin is attractive because it can be given orally and is less likely to sensitize or elicit hypersensitivity in patients.

Two hundred fifty male patients were treated with varying single oral dosages of ampicillin. The criteria for cure were the disappearance of signs and symptoms and a negative culture on Thayer-Martin selective medium. No advantage in increasing ampicillin above a single dose of 0.5 gm. with a failure rate of 15.6 percent. Ampicillin is a useful addition to the therapy of gonorrhea.

Haynes, C. Doyle, M.D., and Davis, M. E., Jr., M.D., Dept. of Surgery, Emory U. School of Medicine, 69 Butler Street, Atlanta, Ga., "Ergotism: Report of Case with Localized Arteriographic Changes in Femoral Vessel," Angiology, The Journal of Vascular Diseases 19:199-202(April) 1968.

Ergotism can give a clinically localized block in a major vessel. The cause appears to be spasm and can be reversed with avoidance of Ergot medication, time, and vasodilator drugs.

The case presented shows the typical radiographic changes seen with major vessel spasm in a patient who was found to have Ergot poisoning. Follow up arteriograms revealed a reversal of the spasm and relief of the arterial block. The patient regained her pedal pulses and became asymptomatic.

From this case, it was inferred that Ergot poisoning can cause a localized spasm in a major vessel, and that anyone complaining of symptoms suggestive of arterial insufficiency should be questioned closely about his use of Ergot-containing medications.

Rieser, Charles, M.D., Emory U. School of Medicine, Atlanta, Ga., "A New Method of Treatment of Inflammatory Lesions of the Female Urethra," JAMA 204:387-384(April 29)1968.

The purpose of this report is to emphasize the importance of the paraurethral ducts as the primary etiologic factor resulting in chronic urinary tract infections of the female urethra. Secondarily, the meatus may become narrowed and fibrotic and its margins characterized by granuloma. Inflammatory response of varying degree involves the mucous membrane throughout the urethra, the bladder neck and the simple tubular glands attached to the proximal ends of the paraurethral ducts. Ofttimes metaplastic alterations of the entire trigone occur, producing the common clinical condition commonly labelled "urethrotrigonitis." A method of surgical therapy has been devised whereby all the infected ducts are readily and permanently ablated and the secondary inflammatory changes destroyed. Two hundred six patients underwent the operation with impressive and consistent success, negligible complications and permanent cure.

Symbas, Panagiotis, M.D., and Parr, John A., M.D., Emory U., Atlanta, Ga., "Early Surgical Treatment for Acute Pneumococcal Aortic Valvulitis with Aortic Insufficiency, Acquired Ventricular Septal Defect, and Aortico-right Ventricular Shunt, Annals of Surgery 167:580-585(April) 1968.

The complications of acute bacterial endocarditis of aortic valve, valve ring abscesses, perforation of the sinus of Valsalva into the right ventricle or pericardium, myocarditis, coronary embolus, perforation of the aortic valve and interventricular septum can greatly increase the mortality and can force the decision to institute surgical treatment before an adequate antibiotic therapy has been accomplished.

This was the case with a 44 year-old alcoholic male who was treated at Grady Memorial Hospital. He was admitted confused and disoriented with clinical, chemical and bacteriological findings of pneumococcal meningitis and normal heart. Immediate treatment with intravenous infusion of massive doses of penicillin was begun. On the second hospital day a faint early diastolic murmur was heard and on the sixth day it became more pronounced and he developed congestive heart failure. On the seventeenth hospital day a grade IV continuous murmur was first heard and his congestive heart failure became uncontrollable. Cardiac catheterization showed a left-to-right shunt at the ventricular level and on ascending aortogram demonstrated severe aortic regurgitation. On the twenty-second hospital day he was operated upon. A 2 cm. in diameter fenestration in the right coronary cusp and a 5-6 cm. in diameter ventricular septal defect extending to the annulus of the aortic valve were found and the left cusp was avulsed close to the commissure. The ventricular septal defect was closed with a Teflon felt patch and the aortic valve was replaced with a Starr-Edwards prosthesis.

The postoperative course was complicated with complete heart block, which disappeared after four days of continuous cardiac pacing, and low cardiac and urinary output, which were treated with intravenous isoproterenol and dopamine infusion. He recovered completely, was discharged 28 days after surgery and is doing very well over a year and a half after surgery.

THE ASSOCIATION

NEW MEMBERS

Adair, Harold E., M.D. Active—Fulton	478 Peachtree St., N.E. Atlanta, Georgia 30308
Balbona, Jose L., M.D. Active—Fulton	1999 Cliff Valley Way, N.E. Atlanta, Georgia 30329
Biggers, William H., M.D. Active—Fulton	1256 Briarcliff Road, N.E. Atlanta, Georgia 30306
Black, Paul W., M.D. Active—Fulton	1938 Peachtree Road, N.W. Atlanta, Georgia 30309
Boyd, Fred D., M.D. Active—DeKalb	3990 Buford Highway Atlanta, Georgia 30329
Brantley, Marvin A., M.D. Active—Fulton	1365 Clifton Road, N.E. Atlanta, Georgia 30322
Briant, Thomas P., M.D. Active—Fulton	401 Peachtree Street, N.E. Atlanta, Georgia 30308
Brown, Nyda W., M.D. Active—Fulton	3056 Slaton Drive, N.W. Atlanta, Georgia 30305
Calvert, John R., M.D. Active—Fulton	Emory Univ. Hospital Atlanta, Georgia 30322
Cline, Allen L., M.D. Active—Cobb	792 Church Street Marietta, Georgia 30060
Evans, James A., M.D. Active—Fulton	80 Butler Street, S.E. Atlanta, Georgia 30303
Franck, George H., M.D. Active—Fulton	6701 Roswell Road, N.E. Atlanta, Georgia 30328
Gordon, Walter C., M.D. Active—Dougherty	413 S. Madison Street Albany, Georgia 31701
Ligon, Walter M., M.D. Active—Cobb	754 Church Street Marietta, Georgia 30060
Machado, M. D., M.D. Active—Fulton	3800 Cascade Road, S.W. Atlanta, Georgia 30331
Martin, Wm. O., III, M.D. Active—Fulton	478 Peachtree Street, N.E. Atlanta, Georgia 30308
Mihalovits, Karl S., M.D. Active—Fulton	3400 Peachtree Road, N.E. Atlanta, Georgia 30326
Palmer, Fred L., M.D. Active—Cobb	3001 S. Cobb Drive Smyrna, Georgia 30080
Robbins, Robert C., M.D. Active—Cobb	52 Tower Road, N.W. Marietta, Georgia 30062
Rodriguez, J. I., M.D. Active—Fulton	2741 Bayard Street East Point, Georgia 30044
Rubio, Victor H., M.D. Active—Thomas-Brooks	Southwestern State Hospital Thomasville, Georgia 31792
Taylor, David M., M.D. Active—Fulton	340 Boulevard, N.E. Atlanta, Georgia 30312
Waters, James L., Jr., M.D. Associate—Fulton	69 Butler Street, S.E. Atlanta, Georgia 30303
Wildey, Roy A., M.D. DE-2—Fulton	69 Butler Street, S.E. Atlanta, Georgia 30303
Wylie, James E., M.D. Active—Fulton	3451 Peachtree Road, N.E. Atlanta, Georgia 30326

SOCIETIES

The second quarterly meeting of the **South Georgia Medical Society** was held June 11 at the Valdosta Country Club. The speaker at the meeting was Dr. Roger F. Palmer, Associate Professor of Pharmacology and Medicine at the J. Millis Miller Health Center, University of Florida. Dr. Palmer spoke to the society on "The Management of Cardiac Arrhythmias."

The Committee on Medicine and Religion of the **Cobb County Medical Society** has been reorganized, and the name has been changed to the Committee on Medicine, Religion and Law. The reorganization is designed to include lawyers on the committee and to bring about a more closely-allied endeavor on the part of doctors, ministers and lawyers in future programs arranged by the committee. Eugene Harley of Smyrna will be in charge of the committee's quarterly programs.

PERSONALS

First District

Robert Howard has been named medical director of the South Atlantic Blood Center of the Red Cross, succeeding **Dr. Caroline J. Williams.**

J. Moultrie Lee was recently named a medical vice president of the local unit of the American Cancer Society.

Three Savannah surgeons recently received notice of certification by the American Board of Orthopedic Surgery. They are **W. C. Rhangos, Julian D. Kelly, Jr.**, and **Eugene Pope Bargeron.**

David Robinson of Savannah has a new associate in his practice of radiology. He is Edward J. Lane, Jr., who will be associated with Dr. Robinson at Candler General Hospital and in his office facilities.

The president of the Georgia Medical Society, **Thomas McGoldrick,** has been elected vice chairman and moderator of the fluoridation study committee of Savannah.

Fifth District

John W. Turner has been named a Fellow in the Royal Society of Medicine in England.

The president-elect of the Georgia Pediatrics Society is **LeRoy Antrobus.** Dr. Antrobus is also a member of the state Pediatrics Committee for Handicapped Children.

At the recent meeting in Biloxi, Mississippi of the Southeastern Society of Plastic and Reconstructive Surgeons, **John R. Lewis, Jr.** was elected vice president of the society, and **William Huger** was elected historian.

Sixth District

Dr. and Mrs. Morgan Kellum of Thomaston and their three sons have returned from Europe after attending the meeting of the American College of Surgeons in Munich. Following the meeting, the Kellums toured Germany, Austria, Czechoslovakia, Hungary, Yugoslavia, Luxemburg, Belgium and Holland.

Claude L. Pennington and **Edward L. Stevens** announce their association in a partnership for the practice of otolaryngology with D. Morton Boyette in Macon.

Seventh District

Luther G. Fortson of Marietta has been re-elected secretary-treasurer of the Georgia Society of Internal Medicine for 1968-69. The election was held during the society's annual meeting in Augusta.

Eighth District

Michael N. Laslie has become associated with **Mack V. Greer** in the practice of medicine in Homerville.

Tenth District

The Life Insurance Medical Research Fund has awarded a $33,000 grant to the Medical College of Georgia for research by **James B. Hudson** on metabolism and cell pH in acidosis and alkalosis.

Roy Witherington has announced the association of H. R. Finney for the practice of urology in Augusta.

D. N. Thompson of Elberton was featured in a story in the *Atlanta Journal.* In the article, Dr. Thompson reminisced about his early practice in Elberton, and the great changes in medicine in the past sixty years.

Charles T. Young has retired after more than 11 years as director of student health and head of the Gilbert Memorial Infirmary at the University of Georgia. His retirement became effective July 1.

HIGHLIGHTS OF EXECUTIVE COMMITTEE OF COUNCIL MEETING, AUGUST 11, 1968—ATLANTA

This summary is being printed so that MAG Officers and Councilors may be advised of the actions of the Executive Committee between meetings of Council. It covers only major actions and is not intended as a detailed report in lieu of meeting minutes.

Title XIX Claims Review Contract—Dr. John T. Mauldin reported on the contents of the two bids submitted to the Department of Public Health by MAG and the Travelers Insurance Company for the contract to perform the function of reviewing all Medicaid claims for certification of usual, customary and prevailing fees, and utilization, and reviewed the steps taken since the submission of the bids. Dr. Richard Smoot, Chairman of the Committee which will make recommendations to the Board of Health on the awarding of the contract has invited the two agencies to meet with his committee on Wednesday, August 14, and Dr. Mauldin will represent MAG at that meeting.

Emory-Grady Agreement—The Executive Committee reviewed a letter from Dean Arthur Richardson in answer to MAG's resolution requesting changes in the Emory-Grady agreement regarding third party payments, and noted with pleasure his stated intention "that the Grady Medical Staff will be fully informed and consulted as to all programs and expenditures pertaining to the fund."

Committee Conclave—Dr. Haverty requested approval of an addition to the Committee Conclave program in the form of an MAG-sponsored dinner for the County Society Executive Secretaries and MAG Headquarters Executive Staff. The Executive Committee endorsed the idea of MAG paying for this dinner with the County Societies being asked to send their Executive Secretaries and pay their other necessary expenses.

Headquarters Building Expansion—The Executive Committee recessed to investigate the situation at the rear of the property and heard Dr. McDaniel discuss the recommendation of the architect that an attempt be made to secure the additional 7.25-foot width necessary to straighten the North boundary line for 114 feet beginning at Cypress Street. The Executive Committee authorized Dr. McDaniel to secure a drawing from the architects showing improvements which could be made to the adjacent property, and to negotiate with those property owners for the purchase of that additional space.

Other Matters Discussed Were as Follows:

—Heard a letter from Alston, Miller and Gaines noting that the Fulton Superior Court had issued a

temporary injunction to prohibit payment by the Health Department for drugs prescribed by Osteopaths until the case can be heard August 27.

—Received the letters from the two Medical School Deans and the Board of Medical Examiners regarding their approval of consideration of the FLEX medical licensing examination, and noted that the matter of MAG endorsement was being considered by the Medical Education Committee.

—Approved a letter written by the Hospital Activities Committee to the Hart County Medical Staff expressing MAG's position regarding Governing Boards of Hospitals.

—Recognized the contribution of Dr. Cyrus W. Strickler, Jr., as he steps down as Chairman of the Medical Advisory Committee to Selective Service.

BLUE SHIELD INTRODUCES NATIONAL ACCOUNT CARD

Physicians and their office assistants will be seeing more patients carrying Blue Shield's new identification card designed for subscribers in certain "national account" groups. This new national account ID card is being given to employees of large national organizations whose employees are located in different areas of the country, involving a number of Blue Shield Plans.

Will Expedite Processing

Use of the new card will help to expedite the processing of claims by facilitating the determination of a subscriber's eligibility for benefits. In addition, such a card will preclude the necessity for re-issuing ID cards when employees move from one Blue Shield area to another. This national account card is used in combination with central certification, an administrative system devised by Blue Shield and Blue Cross, to provide certain national buyers of health coverage with a uniform set of benefits and to give the providers of care a means of identifying eligible subscribers from outside the local area.

Medical and hospital benefits for employees are uniform within centrally-certified groups, regardless of where the individual employee may be located.

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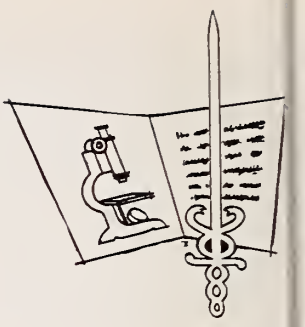
CANCER PAGE



CANCER: CURRENT CONCEPTS AND MANAGEMENT

DANIEL B. SULLIVAN*

"CANCER—CURRENT CONCEPTS AND MANAGEMENT," a seminar to present additional clinical training to the diagnosis and management of cancer in the major sites, with the exception of lung cancer, will be conducted November 11, 12, and 13 at the Medical College of Georgia in Augusta.

Co-sponsors for this seminar are: American Cancer Society, Georgia Division, Fort Gordon Hospital, Medical College of Georgia, Richmond County Medical Society, Savannah River Plant of the Atomic Energy Commission and the Veteran's Administration Hospital in Augusta. Fourteen hours credit has been approved by the American Academy of General Practice.

Outstanding Faculty

A corps of outstanding physicians in various fields of cancer control will serve as the faculty. These include:

Alexander Brunschwig, M.D., Attending Surgeon Emeritus, Gynecology Memorial Hospital, New York, New York;

Max Cooper, M.D., Professor of Pediatrics, School of Medicine, University of Alabama, Birmingham, Alabama;

Eugene P. Cronkite, M.D., Chairman, Medical Department, Brookhaven National Laboratory, Upton, Long Island, New York;

Calvin Dillaha, M.D., Professor of Medicine and Chief of Dermatology School of Medicine, University of Arkansas, Little Rock, Arkansas;

Robert L. Egan, M.D., Professor of Radiology, School of Medicine, Emory University, Atlanta, Georgia;

Gilbert H. Fletcher, M.D., Professor of Radiotherapy and Head, Department of Radiotherapy, University of Texas, M. D. Anderson Hospital and Tumor Institute, Houston, Texas;

Ralph E. L. Hertz, M.D., Assistant Attending Surgeon, Rectal and Colon Service, Memorial Hospital, New York, New York;

Jerome A. Urban, M.D., Associate Attending Surgeon, Breast Service, Memorial Hospital, New York, New York;

The three day session is dedicated to those sites that will have the greatest potential cure rate if diagnosed early and treated properly, and is designed to give all physicians a unique learning experience.

Other Activities Planned

Other activities of interest that are planned during the three days are special luncheons with the guest speakers for a limited number, a tour of Vietnam Village

* *Member Board of Directors, American Cancer Society, Georgia Division, Chairman of Seminar.*

at Fort Gordon, a tour of the Physical Health Laboratories of the Savannah River Plant, golf at the Augusta Country Club and special activities for their wives.

Official programs and reservation information will be sent out in September from the Medical College of Georgia. Physicians who are interested in attending this seminar should contact either the American Cancer Society, 2025 Peachtree Rd., N.E., Atlanta, or the Division of Continuing Education, Medical College of Georgia, Augusta if registration information is not received. Seminar headquarters will be the Augusta Town House.

EMORY PHYSICIAN RECEIVES GRANT FOR CANCER STUDY

A new approach to the control of cancer will be studied at Emory University with the aid of a $136,064 grant from the John A. Hartford Foundation, Inc., New York City. The grant was announced recently by Ralph W. Burger, president of the Foundation, and Dr. Arthur P. Richardson, dean of the Emory medical school.

Dr. Loren J. Humphrey of the department of surgery at Emory will conduct the research using the facilities of hospitals in the Woodruff Medical Center and special laboratories in the Woodruff Building.

Cancer "Vaccine"

Dr Humphrey said earlier research has shown promising results from immunotherapy. The first studies were with patients with advanced cancer. Tumor tissue taken from a patient with cancer is made into a "vaccine" Dr. Humphrey said. The vaccine is a tumor preparation which will immunize but will not cause a tumor.

"This vaccine is given to a second patient with cancer or, after further testing, will be given to a healthy volunteer from the patient's family," Dr. Humphrey said.

Help for Advanced Cases

After the person is sufficiently immunized with the vaccine, he will donate plasma and white blood cells to the original cancer patient. The preliminary study showed that this type of passive immune therapy (like serum therapy used for pregnant mothers exposed to German measles) was helpful in the patients with advanced cancer. It is anticipated that the therapy will be even more effective for the patient in the early stages of cancer.

"In addition, for certain types of cancers, immune therapy will eventually be used with some of the currently administered anti-cancer drugs.

Immunologic Studies Are Crucial

"While immune therapy is being used at several places in the U.S. for the treatment of advanced cancer, immunologic studies performed with the therapy are a unique and crucial part of this project," he commented.

An associate professor of surgery in Emory's medical school, Dr. Humphrey recently came to Emory from the University of Kentucky medical school. He received his B.A. at Albion College, his M.D. at the University of Illinois in Chicago, his Ph.D. in immunology at the State University of New York at Buffalo.

GEORGIA REGIONAL MEDICAL PROGRAM AWARDED OPERATIONAL GRANT

The Georgia Regional Medical Program has been awarded $1,416,777 in operational funds by the U.S. Public Health Service for the first of a three-year program.

Approval of the grant, which puts Georgia among the first 25 of the nation's 54 regions to move from the planning stage to the operational phase, was announced in Washington by Senators Russell and Talmadge and in Atlanta by Program Coordinator J. W. Chambers, M.D., and Program Director J. Gordon Barrow, M.D.

Fourteen research, training and clinical projects will be underwritten by the grant, seven of which are in the area of continuing education. The Federal funds were granted through MAG, which serves as official applicant and fiscal agent for the heart, cancer, stroke program in Georgia.

A more detailed report and description of these initial projects has been mailed to every physician throughout the State. The projects, all of which have statewide application, will be implemented in stages throughout the next year. Additional proposals for further funding are being submitted to Washington this month following approval of GRMP's Regional Advisory Group. The principal projects will be described in depth in subsequent issues of the Journal.

MAG HOLDS EIGHTH ANNUAL CONFERENCE ON SPORTS INJURIES

The Medical Aspects of Sports, an activity of the MAG Committee on School Child Health, held its Eighth Annual Conference on August 8, 1968, in Macon. The Conference was held in conjunction with the annual meeting of the Georgia Athletic Coaches Association.

Purpose of Conference

This meeting is traditionally open to all physicians, coaches, athletic trainers, and interested school officials. Its purpose is to highlight those aspects of competitive athletics wherein conditioning, training and treatment will result in a decrease in the number of sports injuries and an improvement in treatment techniques.

The date and site of the 1968 Conference was selected to coincide with the state high school all football and basketball games thus insuring a large attendance from among the ranks of high school athletic coaches and trainers.

The program was highlighted by physician guest speakers as well as several panel discussions on conditioning as a preseason precaution for football; knee problems in athletics including prevention, treatment and rehabilitation; and nutrition.

The panel on nutrition was held during a complimentary luncheon sponsored by the Florida Citrus Commission.

Guest Speakers

Dr. Martin Blazina, team physician for the University of California at Los Angeles, delivered a paper on "Recurrent Subluxation of the Shoulder." Dr. Blazina is a member of the Sports Medicine Committee of the American Academy of Orthopaedic Surgeons. Dr. Loui G. Bayne, Atlanta, spoke on "Athletic Injuries of The Hand"; and Mr. John E. Roberts, Executive Director of the Wisconsin Interscholastic Athletic Association spoke on the insurance benefits plan developed in Wisconsin for the coverage of high school athletes and non-athletes.

Participants in the Eighth Annual Conference on Sports Injuries include (left to right) John E. Roberts, Executive Director, Wisconsin Athletic Association Benefit Plan, Loui G. Bayne, M.D., of Atlanta, Martin Blazina, M.D., Team Physician for UCLA, and Fred L. Allman, M.D., co-chairman of the conference.

Additional physician and lay members of the various panels were: Jack C. Hughston, M.D., Columbus; William E. "Butch" Mulherin, M.D., Athens; John T. Dupree, M.D., Macon; John H. Robinson, M.D., Americus; William Earl Lewis, M.D., Macon; Maurice F. Arnold, M.D., Hawkinsville; Mr. Sam Burke, Thomaston, Georgia, President, National Federation of High School Athletic Associations; Mr. Warren Morris, Athens, Head Athletic Trainer, University of Georgia; and Messers Max Ivey and Elmer Morrow, Directors of the public school systems' Athletic Departments in Fulton and DeKalb Counties respectively.

IS AMERICA REALLY SICK?

Every year from Labor Day until Thanksgiving, some 8,400,000 American citizens, all volunteers, desert their offices, homes, their industrial plants, business firms and leave skeleton staffs to double up and mind the store while they pound the city streets and suburban avenues to raise money for 2,225 United Funds throughout the nation.

United Funds, in some communities called the United Way, Community Chest or United Appeal, help support 31,100 local, State and national voluntary health and welfare agencies. Every year, more than 27,000,000 American families are helped by United Fund humanitarian services and programs, more families than assisted by any other voluntary effort.

America is weathering a year filled with tragedy and despair. People in high places and low are saying America is sick. We say America is not all that sick. It is still vital and alive and the people of America are concerned about the well-being of all people—the ill, elderly and handicapped; fatherless children and their mothers; boys and girls and their futures; the troubled and mentally disturbed. United Funds, tremendous voluntary efforts, attest to this.

People are helped when you help the United Way. Healthy, literate contributing people are a healthy America. Pledge your Fair Share now.

THE MONTH IN WASHINGTON

"Improving the quality of life in this country requires that far greater national effort be devoted to reducing the incidence of preventable diseases, accidents and premature death." This was the theme of a proposal to President Johnson to establish a Commission on Disease Prevention and Health Protection, appointed by the President, to make recommendations within a year.

Emphasis on Preventive Medicine

The President was told that "to continue the present national emphasis upon treatment and after-the-fact remedies, as opposed to prevention, must be regarded as a failure of the health professions to adequately protect the public."

Said the plan's sponsors, headed by Senator Warren Magnuson (D., Wash.), Chairman of the Senate Commerce Committee:

"Many of the diseases currently prevalent can be prevented entirely. Others can be detected and cured in the early stages. In some cases, it is simply a question of instilling awareness, recognizing symptoms or the importance of diet, and exercise. Technical personnel and automated laboratory and computerized recording procedures can utilize known techniques to operate comprehensive screening programs. These prevention and early detection programs can save money and conserve scarce physician time. People can be educated to expect health rather than to tolerate illness, to demand prevention rather than to admire belated treatment."

Numerous Approaches

The statement continued: "Benefits can be derived through legislation. Others will accrue through public and professional education. Still further benefits would come from financial support for special professional and non-professional training in the practice of preventive medicine. The following are just a few examples of things that can be done now. For example, we now have the authority to clean the polluted air over most of the major urban areas of this country.

"Other approaches include new methods of paying for and organizing health services. We, at present, invest huge sums in medical care, through public and private support. The same means of coverage, however, such as Title XVIII, do not provide for 'health protection': there is no payment for periodic health appraisal on an out-of-hospital basis, with provision for follow-up care. This should include individual and group counselling services necessary for health maintenance, given by a physician or other health professional."

Encourage Medical Schools

The Magnuson group said that "despite the convincing case for prevention, about two-thirds of all medical schools do not have departments of preventive medicine. This lack is appalling. We should at once encourage the establishment, or strengthening, of these departments in all medical schools, and emphasize a more realistic training program for the physicians of tomorrow."

Supplemental Report on Smoking

The 1968 supplemental report on Smoking and Health of the Surgeon General of the Public Health Service reaffirmed that cigarette smoking is a health hazard. The report was sent to Congress the same day as a Federal Trade Commission recommendation that cigarette advertising be banned from television and radio.

Highlights of the smoking report were:

—New evidence indicating that the life expectancy among young men is reduced by an average of eight years in "heavy" cigarette smokers, those smoking over two packs a day, and an average of four years in "light" cigarette smokers, those smoking less than one half pack per day.

—Cigarette smoking can contribute to the development of cardiovascular disease and particularly to death from coronary heart disease. Some of the harmful cardiovascular effects appear to be reversible after cessation of cigarette smoking.

—New evidence that the previous finding that cigarette smoking is the most important cause of chronic bronchopulmonary disease in the United States.

—Additional evidence that cigarette smoking is a main cause of lung cancer in men and is casually related to lung cancer in women.

NIH Director Appointed

Dr. Robert Q. Marston was appointed to succeed Dr. James A. Shannon as director of the National Institutes of Health, effective September 1.

Dr. Marston, 45, had been administrator of the NIH's Health Services and Mental Health Administration since April 1. He went with the NIH in 1966 as the first administrator of the Heart Disease, Cancer and Stroke Regional Medical Programs. Before that, he had been vice chancellor and dean of the University of Mississippi Medical School.

Dr. Marston, in accepting his new post, listed knowledge first and then money and manpower as the key factors in future improvements in the health of Americans. "The ultimate constraint of our ability to effect the health of the people is neither dollars nor manpower, but the knowledge gained through research," he said.

"A major problem of the future will be to insure institutional stability, during times of manpower and fiscal shortages on which future [medical research] success is dependent."

In appointing Dr. Marston, President Johnson said the new NIH director faces a "staggering job" because not only the United States, but the entire world needs "rescue from death and disability that medical research promises."

Johnson expressed the hope that Dr. Marston's leadership in research would play an important role in an effort to reduce the death rate from serious diseases by 10 per cent by 1976.

Memorial Center Established

The John E. Fogarty International Center for Advanced Study in the Health Sciences has been established in memory of the late Rhode Island congressman who was a leader in health legislation for many years. Congress provided an initial appropriation of $500,000 for the new center to start operation in the National Institutes of Health until its own building is completed.

The center's first director is Dr. Milo D. Leavitt, Jr., who had been director of the NIH Office of Program Planning.

Appeal for Public Cooperation

U.S. Attorney General Ramsey Clark appealed for broad support and cooperation of the public in enforcement of the laws against marijuana and LSD. Otherwise, he said, the law cannot be enforced effectively.

Committee on Birth Control

President Johnson named a special committee to develop a five-year program for providing more effective birth control. The study committee will be headed by HEW secretary Wilbur J. Cohen; Mrs. John D. Rockefeller, III, N.Y., will serve as his co-chairman. An official said one matter to be studied would be the fact that present methods of contraception are not adequate. He said the so-called "pill" is too expensive for widespread use in some areas and it was difficult to educate illiterate people in its use.

Pooled Plasma Shipments Halted

The National Institutes of Health has asked processors of whole pooled human blood plasma to halt its interstate shipment because the substance has been causing hepatitis, an infection of the liver, in one out of 10 patients receiving transfusions. The move is expected to halt use of most such plasma of which about 300,000 pints are given annually to about 100,000 patients in the United States. The agency acted on a report issued in April by the National Research Council saying use of whole pooled plasma should be discouraged and even discontinued because of the hepatitis danger.

Economics of Alcoholism

The Senate Health Subcommittee was told that the nation talks more and does less about its 5 million alcoholics than any of its other health problems. Michael Gorman, a spokesman for the National Council on Alcoholism, said that the losses from alcoholism are now running about $2 billion a year. Dr. Philip R. Lee, Health, Education and Welfare Assistant Secretary, supported Gorman. According to Dr. Lee, alcoholism was an "enormous economic liability to the nation" in terms of job absenteeism, lowered productivity, and medical insurance expenses.

PHYSICIAN COMPLETES TOUR ABOARD S.S. HOPE

Robert B. Quattlebaum of Valdosta returned in m'd-August after completing a two-month voluntary tour aboard the hospital ship S.S. HOPE in Colombo, Ceylon.

HOPE is in Ceylon by invitation of the Ceylonese government and Ceylonese medical association. The ship's staff of 150 physicians, dentists, nurses and paramedical personnel works directly with Ceylonese counterparts in classrooms, laboratories and wards aboard the ship and in hospitals, medical schools and clinics ashore.

HOPE's mission in Ceylon marks the hospital ship's first return to Asia since her maiden voyage in 1960-61 when she visited Indonesia and South Vietnam. Since then Project HOPE has conducted medical teaching and treatment programs in Peru, Ecuador, Guinea, Nicaragua and Colombia. Follow-up programs continue in four of these nations.

Founded in 1958 by Dr. William B. Walsh, Project HOPE is the principal activity of The People-to-People Health Foundation, Inc., an independent, non-profit organization headquartered in Washington, D.C., and supported by the American people.

Since the first voyage, more than 1,200 American medical personnel have served with HOPE. They have trained more than 4,000 medical personnel in developing nations, treated over 120,000 persons, conducted nearly 11,000 major operations, and benefitted more than two million persons through immunization, examinations and other services.

GEORGIA HIGHWAY SLAUGHTER

Yearly Totals

1968 to date	935 Killed
1967	1,621 Killed
1966	1,605 Killed
1965	1,354 Killed
1964	1,314 Killed
1963	1,278 Killed
1962	1,106 Killed
1961	1,017 Killed

Through July, 1968
935 KILLED

Same Period 1967
913 KILLED

July, 1968
141 KILLED

Economic Loss

1968 to date	$177,650,000
1967	291,780,000
1966	288,900,000
1965	243,720,000
1964	236,520,000
1963	230,040,000
1962	199,080,000
1961	162,720,000

USE OF PEROXIDE OF HYDROGEN IN DISEASES OF THE THROAT AND NOSE

By P. R. CORTELYOU, Marietta, Georgia

Having had my attention called to this medicinal agent, while on a visit to New York, last September, I decided to give it a trial, and now report a few cases, of many, in which I have used it.

The Peoroxide of Hydrogen, H^2, 6^2, was discovered in 1818, by Thenard, a French chemist, by adding dilute acid to the peroxide of barium. It was introduced to the medical world by Dr. B. W. Richardson. It is an aqueous solution, in distilled water, of an-hydrous peroxide of hydrogen, H^2, O^2.

According to the testimony of many French and German physicians and chemists, it is a very strong anti-putrid agent.

It is a colorless, transparent liquid, and does not decompose if kept in temperature not above 68°. It is claimed, by many, to have strong antiseptic properties, and to have a specially beneficial effect on all mucous membranes, purifying and cleansing secretions, and stimulating the membrane to healthy action. Therefore, it should be a valuable therapeutic agent in all cases where there is an unhealthy and excessive secretion, on mucous membranes.

In all my cases I have used a 15-volume solution C. P., for medicinal use, as prepared by Charles Marchand, of New York, and have diluted it one-half or two-thirds, as the case demanded, using the fluid in form of fine spray, by means of compressed air, as contained in Hygienic Air Receiver, made by the Standard Pump Manufacturing Company, of New York, and using pressure of fifty pounds to twenty pounds to square inch, with the "Sass. spray tubes."

Case 1.—Mrs. F. Consulted me October, 1887, about her throat and nose. Examination revealed chronic pharyngitis and rhinitis, of long standing, and with excessive secretion of unhealthy mucous and hardened lumps, causing her to continually hawk and clear the throat; the dropping in the throat also causing her to cough frequently.

On inspection, found pharynx covered with tenacious, glairy mucous, and the mucous membrane of the nostrils in the same condition.

Used hydrogen peroxide, 15-volume solution, diluted one-half with Sass. spray, and pressure of thirty pounds to square inch; throwing spray in throat, and also through both nostrils. Then applied a solution of tinct. iodine, one drachm; bromide potassium, twenty grains; glycerine six drachms, to the throat and posterior nares. This line of treatment was continued every other day for two weeks.

The improvement was rapid and marked, and the patient gained in flesh and strength, and was relieved of the hawking and dropping of the mucous in the throat.

Case 2.—Mrs. C. Consulted me October 15th, 1887. Had suffered with nasal and pharyngeal catarrh, so that she was constantly clearing throat and nose. Also troubled with deafness and ringing in the ears. Examination showed throat inflamed, mucous follicles enlarged, and hardened masses of greenish mucous behind soft palate. Used hydrogen peroxide, 15-volume solution, diluted one-third with spray, forty pounds to the square inch, to the throat and nose, thus cleansing membrane thoroughly, and then applied the solution of iodine, potash and glycerine. This treatment used every other day. Patient improved rapidly, and, in course of few weeks, was so much relieved that she discontinued treatment.

Case 3.—Mrs. K. Consulted me November 3d, 1887. Complained of cough and soreness of throat, with feverishness and loss of strength. Physical examination revealed marked deposit at apex of left lung, with tendency to softening. Throat much inflamed and irritable, causing her to cough constantly.

Used peroxide hydrogen, 15-volume solution, diluted one-half, with spray, under thirty pounds pressure to square inch; then applied a four per cent solution of muriate of cocaine, followed by the iodine, potash and glycerine solution.

The treatment relieved the throat very much, and, under it, the cough diminished and appetite and strength improved. After four weeks, the throat was feeling so much better that the treatment was only given once or twice a week, and patient has kept in good condition all Winter.

Case 4.—Mrs. P. Consulted me December 12th, 1887, complaining of cough, fever, weakness, and much pain and distress in the throat, causing pain in eating.

Examination revealed extensive deposit, in right lung, of catarrhal character, and evidences of softening. Throat much inflamed, and covered with glairy mucous, and very tender and irritable. Used hydrogen peroxide, 15-volumes, as spray, diluted one-half, with

From the Transactions of the Medical Association of Georgia, Thirty-Ninth Annual Session, 1888, Macon, Georgia.

forty pounds pressure. Then applied four per cent solution of muriate of cocaine, followed by iodine and potash solution.

Each application gave much relief, and eased and lessened cough.

Condition of throat improved very much, and patient was thus kept from running down.

CASE 5.—Mr. H. Consulted me January 5th, 1888. Complaining of cough, soreness of throat, and obliged to be continually clearing throat.

Examination revealed slight deposit at apex of right lung, with chronic pharyngitis, mucous follicles much enlarged, and tough mucous covering pharynx. Has used tobacco freely, smoking and chewing; also stimulants, but not at present.

Used hydrogen peroxide, 15-volume solution, diluted one-half with spray, at forty pounds pressure, and applied iodine and potash solution. This treatment, continued every other day for one month, greatly relieved throat, and cough lessened and his condition much improved.

CASE 6.—March 18th, 1888. Called to see Miss M., aged about thirteen years. Said to be sick with diphtheria. Examination revealed well marked case of follicular inflammation of tonsils, with numerous white patches on each.

Used hydrogen peroxide, 15-volume solution, full strength, with hand spray, every few hours. Also applied glycozone, with absorbent cotton, to parts, every few hours. The next day all appearances of deposit had disappeared on one side, and nearly all on the other, rendering it unnecessary to see the patient again.

From the results obtained in the few cases I have mentioned, and many similar ones, I have been led to conclude that in peroxide of hydrogen we have a valuable remedy in all cases of diseases of mucous membranes, whether simple or the result of germs. I should also consider it to be useful in indolent ulcers and sores.

DOCTORS BACK RESEARCH TO CONQUER OBESITY

Physicians engaged in the practice of treating obese patients have formed a non-profit organization, with headquarters in Washington to launch an all-out research effort to pinpoint the mysteries underlying this major health problem in the United States. Incorporated as The Research Institute of Metabolism and Nutrition, the non-profit organization's number one objective is to support and assist the practicing physician in his unceasing efforts to upgrade medical care for the obese patient.

Howard E. Retzer, M.D., of Englewood, Colorado, is president of the new organization. Other officers are Drs. Howard T. Lewis, Jr., vice president, Pittsburgh, Pennsylvania; Edward LaCroix, secretary-treasurer, Fort Worth, Texas, and Harold Harper, sergeant-at-arms, North Hollywood, California.

Upgrade Care of the Obese

Dr. Retzer explained, "Thousands of doctors currently are treating obese patients and more and more doctors are constantly being called on to treat this illness. Many doctors, either from a time or knowledge standpoint, can do relatively little to help these people. It is for this reason that we have established the Research Institute—to conduct research and to provide the resulting information to physicians so that they can help more and more patients overcome this affliction."

The Research Institute's president noted, "It is medicine's responsibility to be ever watchful of new ways to help the patient. Not enough research has been done in the area of obesity and related nutritional ills to help the medical profession achieve this goal. It is our intention to provide a substantial beginning."

Will Support Research

The Research Institute of Metabolism and Nutrition intends to support original research in metabolism and nutrition at major universities and medical centers and to encourage more undergraduate and postgraduate work in these areas. It will conduct public education programs to give the layman a better understanding of the contributing causes of obesity. The organization will also sponsor education seminars to keep physicians abreast of the latest information in this field as it develops.

"Successful weight reduction is not simply a matter of pushing oneself away from the dinner table as many believe," said Dr. Retzer. "Recent studies have shown that the majority of obese people are afflicted with some internal disorder which must be treated first before one can start losing weight and hope to keep it off. Yet, more and more inexperienced laymen are entering the weight reduction field with little or no idea of the hazards of too rapid a weight loss. The obese person must be continuously under the supervision of a physician and should not depend for help solely on the numerous lay-sponsored weight control clubs in existence," he remarked.

Prone to Disease

Recent studies, covering 1,000 patients and controls, showed that obese people are more than normally prone to a host of life-threatening or disabling diseases. Nearly half of this test group had some significant disease along with their weight problem, including, in order of frequency, diabetes, arthritis, heart disease, gout, high blood pressure, kidney disease, excessive cholesterol, hernia, thyroid disease, colitis and peptic ulcers.

Dr. Retzer pointed out, "The incidence of significant disease in overweight people, as uncovered by these studies, is one more reason why such patients should begin any reducing effort by going to a doctor or clinic for a medical checkup."

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Vitamin B_2	7.5 mg
Vitamin B_6	7.5 mg
Vitamin B_{12}	50 mcgm
Vitamin C	200 mg
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* anticostive, *adj.* (*anti* opposed to + *costive* causing constipation.) Against constipation. Now isn't that a good idea in an iron-containing hematinic?

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1968 CALENDAR OF MEETINGS

September 28-29—Georgia Society of Anesthesiologists, Atlanta.

October 4-5—Regional Conference on Health Care Costs, Executive Park Motel, Atlanta.

October 29-November 1—American Society of Tropical Medicine and Hygiene, Biltmore Hotel, Atlanta.

November 15-16—Georgia Academy of General Practice, DeSoto Hilton Hotel, Savannah, Ga.

December 6-7—American Rheumatism Association, Regency-Hyatt House Hotel, Atlanta.

National

September 15-20—International Congress on Alcohol and Alcoholism, Shoreham Hotel, Washington, D.C.

September 16-19—American Hospital Association, Chalfonte-Hadden Hall, Atlantic City, N.J.

September 18-20—National Cancer Conference, Denver Hilton Hotel, Denver, Col.

September 19-22—American Medical Writers Association, Mayflower Hotel, Washington, D.C.

September 21-22—American Academy of Pediatrics, Allenberry-on-the-Breeches, Gettysburg, Penna.

September 22-24—Medical Progress Assembly, Parliament House, Birmingham, Ala. (14 hours Category 1 AAGP credit).

September 22-25—American Fracture Association, Hotel America, Houston, Tex.

September 25-27—American Association of Medical Clinics, The Roosevelt, New Orleans, La.

September 27-28—American College of Physicians, (Southeastern Regional), Happy Dolphin Inn, St. Petersburg Beach, Fla.

September 27-28—American Society of Neuroradiology, Jung Hotel, New Orleans, La.

September 28-October 3—International College of Surgeons, United States Section, Honolulu, Hawaii.

September 30—Society for Pediatric Radiology, Jung Hotel, New Orleans, La.

September 30-October 1—AMA Congress on Occupational Health, Waldorf-Astoria Hotel, New York, N.Y.

October 1-4—American Roentgen Ray Society, Jung Hotel, New Orleans, La.

October 2-3—Fourth National Congress on Health Quackery, Drake Hotel, Chicago, Ill.

October 2-4—Clinical Orthopaedic Society, Roosevelt Hotel, New Orleans, La.

October 4-8—International Congress on Diseases of the Chest, Washington-Hilton Hotel, Washington, D.C.

October 5-6—AMA National Congress on Medical Ethics, Drake Hotel, Chicago, Ill.

October 9-11—New York University Postgraduate Course on "Clinical Electrodiagnosis of Neuromuscular Diseases," New York University Medical Center, New York, N.Y.

October 10-12—American Thyroid Association, Statler Hilton Hotel, Washington, D.C.

October 11-19—American Society of Clinical Pathologists, Fontainebleau Hotel, Miami Beach, Fla.

CALENDAR / Continued

October 12-18—College of American Pathologists, Fontainebleau Hotel, Miami Beach, Fla.
October 14-18—American College of Surgeons, Dennis Hotel, Atlantic City, N.J.
October 17-19—Association of American Physicians and Surgeons, Roosevelt Hotel, New Orleans, La.
October 19-23—Annual Meeting of American Society of Anesthesiologists, Washington Hilton Hotel, Washington, D.C.
October 19-24—American Academy of Pediatrics, Palmer House, Chicago, Ill.
October 27-30—American College of Gastroenterology, Statler-Hilton, Boston, Mass.
October 27-31—American Dental Association, Fontainebleau and Eden Roc Hotels, Miami Beach, Fla.
October 27-November 1—American Academy of Ophthalmology and Otolaryngology, Palmer House, Chicago, Ill.
October 27-November 1—American Society of Plastic and Reconstructive Surgeons, Roosevelt Hotel, New Orleans, La.
October 28-31—American Association of Blood Banks, Shoreham Hotel, Washington, D.C.
October 31—American Association for Study of Liver Disease, Sheraton-Chicago Hotel, Chicago, Ill.
November 1-4—Association of American Medical Colleges, Shamrock Hilton, Houston, Tex.
November 4-7—American Institute of Ultrasonics in Medicine, Monteleone Hotel, New Orleans, La.
November 7-9—Second Annual Conference on "Today's Hospital Problems: An Interdisciplinary Approach," Tides Hotel and Bath Club, Redington Beach, Fla. (18 accredited hours by AAGP).
November 7-10—Association of Clinical Scientists, Shoreham Hotel, Washington, D.C.
November 10-14—American School Health Association, Pick-Fort Shelby, Detroit, Mich.
November 11-15—American Public Health Association, Cobo Hall, Detroit, Mich.
November 13-16—National Easter Seal Society for Crippled Children and Adults, Sheraton-Boston Hotel, Boston, Mass.
November 14-16—Southern Thoracic Surgical Association, Puerto Rican Sheraton, San Juan, Puerto Rico.
November 18-21—Southern Medical Association, The Rivergate, New Orleans, La.
November 19-20—Council on Arteriosclerosis, Balmoral Hotel, Bal Harbour, Fla.
November 21-26—American Heart Association, Americana Hotel, Bal Harbour, Fla.
November 22-23—Southern Society for Pediatric Research, Roosevelt Hotel, New Orleans, La.
November 29-30—National Federation of Catholic Physicians' Guilds, Miami Beach, Fla.
December 1-4—American Medical Association, Clinical Convention, Miami Beach, Fla.
December 1—AMA National Conference on Medical Aspects of Sports, Hotel Deauville, Miami Beach, Fla.
December 3—American Society of Therapeutic Radiologists, Palmer House, Chicago, Ill.
December 4-7—American Medical Women's Association, Statler-Hilton Hotel, Boston, Mass.
December 6-7—American Federation for Clinical Research, Somerset Hotel, Boston, Mass.
December 7-12—American Academy of Dermatology, Palmer House, Chicago, Ill.
December 9-11—Southern Surgical Association, Boca Raton Hotel and Club, Boca Raton, Fla.
December 10-14—American Academy for Cerebral Palsy, Americana Hotel, Bal Harbour, Fla.
December 13-15—American Academy of Psychoanalysis, Royal Orleans Hotel, New Orleans, La.

G.P.'s TO HOLD ANNUAL SESSION IN SAVANNAH

The Georgia Academy of General Practice will hold its Twentieth Annual Session on November 15-16, 1968, at the new DeSoto Hilton Hotel in Savannah.

The program will be divided into two ½-day sessions on Friday afternoon and Saturday morning. The Friday scientific session, which begins at 1:45 p.m. will be preceded by a business meeting of the Academy.

Friday Session

The Friday program is as follows: "Diabetes Mellitis" by Joseph C. Shipp, M.D., University of Florida College of Medicine; "Trivial Injuries of the Hand" by Grady S. Clinkscales, Jr., M.D., Atlanta; "Rehabilitation of the Alcoholic" by James A. Alford, M.D., Emory University School of Medicine.

Saturday Program

The Saturday morning program is as follows: "Value of Palpatation in Diagnosis of Heart Disease" by Ernest Craige, M.D., University of North Carolina School of Medicine: "Sex and Adolescence" by Martha McCranie, M.D., Medical College of Georgia; "Treatment of Infective Cases of Tuberculosis, Active and Inactive" by William Lester, M.D., National Jewish Hospital, Denver, Colorado.

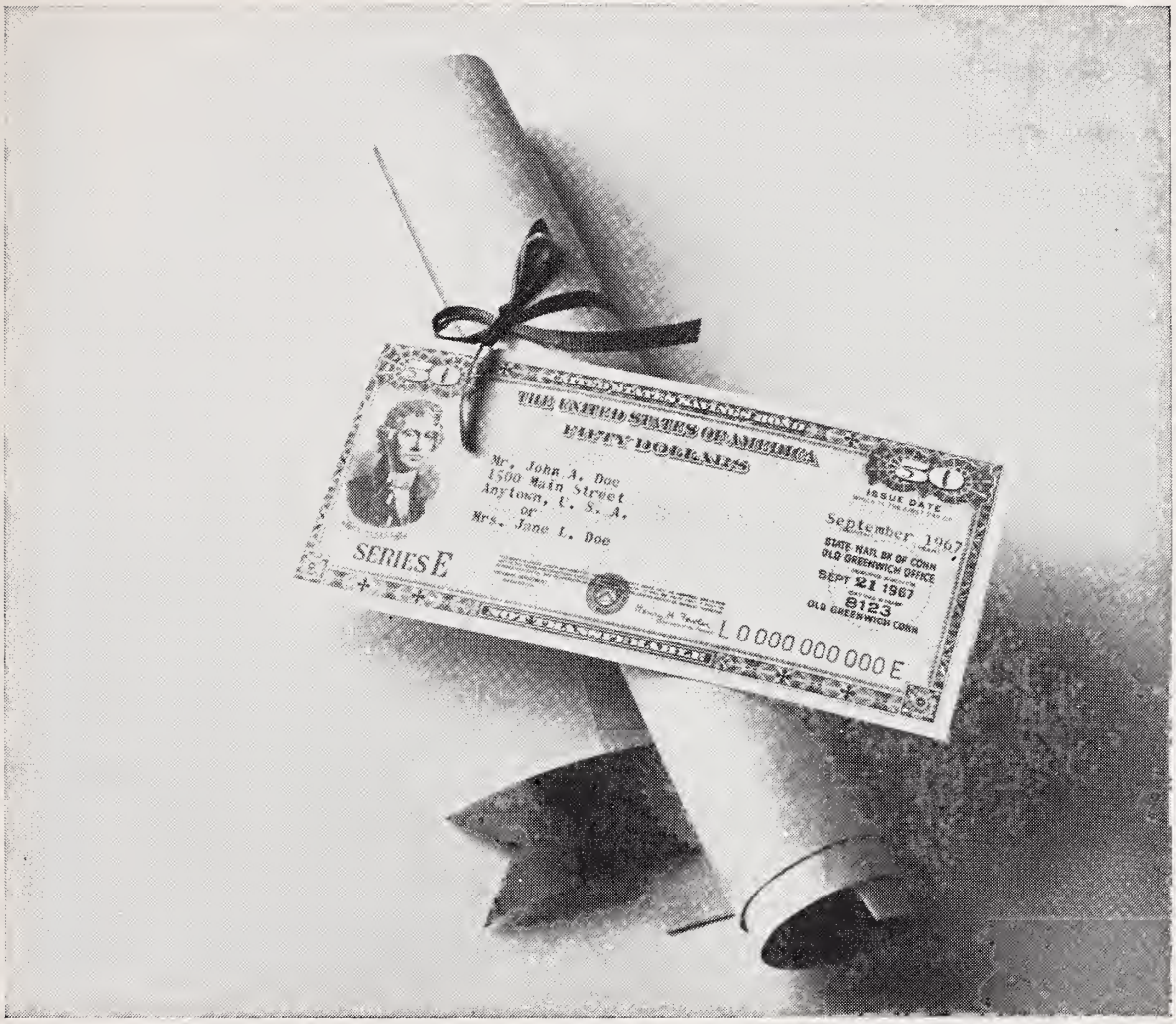
Officers for the coming year will be elected during the meeting.

GROUP BEHAVIOR INSTITUTE HOLDS ANNUAL SEMINAR

Georgia's Fifth Annual Institute on Group Behavior and Group Leadership will be conducted by the Department of Psychiatry, Emory University School of Medicine, at Callaway Gardens on October 9-12, 1968. Program details of this annual forum were released by Dr. William C. Conner, Chairman of the Institute and Director of Group Training at Emory.

The Institute is designed to provide an educational experience for members of the helping professions and others who desire to learn more about the emotional behavior of groups. Participants will be assigned to small groups and meet with skilled leaders in addition to hearing addresses from Jacob Christ, M.D., an outstanding authority on group behavior from Boston, Massachusetts.

For information concerning pre-registration, write or call: Institute on Group Behavior and Leadership, Attn.: Mrs. Louise Hanna, Department of Psychiatry, Emory University, Atlanta, Georgia 30322.



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MEDICAL SOCIETY	PRESIDENT	SECRETARY	MEETING DATE
Altamaha	J. A. Bedingfield, Baxley	H. L. Morgan, Baxley	2nd Wed.
Baldwin	Mahmud Majanovic, Milledgeville	L. J. Jacobs, Milledgeville	
Barrow	G. R. Parkerson, Winder	R. F. Graves, Winder	1st Fri.
Bartow	R. A. Griffin, III, Cartersville	W. C. Holmes, Cartersville	Quarterly
Ben Hill-Irwin	W. C. Sams, Ocilla	Roy Johnson, Jr., Fitzgerald	
Bibb	R. G. Newton, Jr., Macon	S. C. Neuberg, Macon	1st Tues.
Blue Ridge	H. E. Mitzelfeld, Blue Ridge	James Haymore, Blue Ridge	
Bulloch-Candler-Evans	C. G. Hames, Claxton	L. E. Curry, Metter	2nd Tues.
Burke	J. M. Byne, Jr., Waynesboro	C. G. Green, Sr., Waynesboro	1st Tues.
Camden-Charlton	J. M. Jackson, Folkston	H. H. Robinson, Kingsland	1st Mon.
Carroll-Douglas-Haralson	W. S. Worthy, Carrollton	E. H. Grant, Carrollton	1st Mon.
Georgia Medical Society	T. A. McGoldrick, Jr., Savannah	J. J. Holloman, Savannah	2nd Tues. except summer
Chattahoochee	F. A. Sims, Jr., Lawrenceville	Harry Hutchins, Buford	
Cherokee-Pickens	E. A. Roper, Jasper	A. M. Hendrix, Canton	3rd Fri.
Crawford W. Long	Royce Banister, Athens	W. J. Hardman, Jr., Athens	Quarterly
Clayton-Fayette	E. W. Abernathy, Jr., Jonesboro	F. A. Sams, Jr., Fayetteville	3rd Tues.
Cobb	L. G. Fortson, Jr., Marietta	W. T. Williams, Smyrna	1st Tues. after 1st Mon.
Coffee	T. L. Parker, Douglas	W. R. Wills, Jr., Douglas	3rd Tues.
Colquitt	R. M. Joiner, Moultrie	R. E. Fokes, Moultrie	2nd Mon.
Coweta	H. C. Glover, Newnan	F. D. Bass, Newnan	3rd Tues.
Decatur-Seminole	H. H. McNair, Bainbridge	M. A. Ehrlich, Bainbridge	
DeKalb	H. H. Butterworth, Decatur	F. E. Morgan, Jr., Decatur	3rd Mon.
Dougherty	F. D. Guillebeau, Albany	Allen Turner, Albany	
Emanuel	H. W. Smith, Swainsboro	C. E. Powell	2nd Mon.
Flint	O. K. Coleman, Cordele	C. C. Goss, Ashburn	4th Mon.
Floyd	Russell Andrews, Rome	H. R. Connell, Rome	Quarterly
Elbert-Franklin-Hart	L. G. Cacchioli, Hartwell	A. S. Johnson, Jr., Elberton	Quarterly
Fulton	L. H. Bishop, Jr., Atlanta	F. W. Dowda, Atlanta	Monthly on Tues.
Glynn	W. E. Harden, Brunswick	W. A. Snyder, Brunswick	3rd Tues.
Gordon	J. L. Raab, Calhoun	Bill Purcell, Calhoun	
Grady	W. J. Morton, Cairo	S. L. Hancock, Cairo	
Habersham	Bruce Swain, Cornelia	J. B. Edwards, Cornelia	Upon Call Quarterly
Hall	J. K. Burns, III, Gainesville	E. E. Estes, Jr., Gainesville	2nd Mon. except summer
Peach Belt	H. E. Sims, Fort Valley	E. B. Meserve, Warner Robins	
Jackson-Banks	J. L. Griffeth, Commerce	A. A. Rogers, Jr., Commerce	3rd Tues.
Jasper	J. H. Prichett, Jr., Monticello	B. C. Barrow, Monticello	1st Tues.

Jefferson	J. W. Pilcher, Louisville	C. R. Williams, Wadley	Upon Call
Jenkins	A. P. Mulkey, Millen	W. W. Hillis, Jr., Millen	2nd Tues.
Lamar	J. H. Jackson, Barnesville	S. B. Traylor, Barnesville	
Laurens	R. M. Glover, Dublin	Jaime Franco, Dublin	Quarterly
McDuffie	J. W. Lemley, Thomson	T. W. Middlebrooks, Thomson	3rd Mon.
Meriwether-Harris	Edward Haak, Warm Springs	J. L. Robinson, Woodbury	
Mitchell	J. C. Brim, Pelham	A. A. McNeill, Camilla	Last Fri.
Muscogee	C. D. Johnson, Columbus	D. M. Stewart, Columbus	4th Tues. except summer
Newton-Rockdale	R. L. Faulkner, Covington	E. J. Callaway, Covington	3rd Tues.
Oconee Valley	H. A. Thornton, Greensboro	L. J. Wade, Union Point	2nd Thur.
Ocmulgee	Hart Sylvester, Hawkinsville	W. E. Coleman, Hawkinsville	
Polk	T. E. Cummings, Rockmart	J. F. Atha, Rockmart	
Rabun	J. C. Dover, Clayton	Richard J. Turner	2nd Mon.
Randolph-Stewart-Terrell	C. R. Sheffield, Dawson	Mark Allen, Dawson	
Richmond	S. H. Prather, Jr., Augusta	C. S. Mulherin, Augusta	4th Tues. except summer
Screvens	K. R. Hawkins, Sylvania	G. B. Hogsette, Sylvania	2nd Tues.
South Georgia	Harry Mixon, Valdosta	Henry Sherman, Valdosta	
Southeast Georgia	H. I. Conner, Vidalia	G. P. Sassos, Mount Vernon	
Southwest Georgia	James H. Crowdis (1968), Blakely	R. E. Jennings (1968), Arlington	Bimonthly except summer
Spalding	Arthur Krepps, Griffin	Carlos Zevallos, Griffin	3rd Tues.
Stephens	Carlos Barroso, Toccoa	Ken Conoley, Toccoa	Last Tues.
Sumter	J. H. Robinson, Americus	W. R. Anderson, Americus	
Taylor	F. H. Sams, Reynolds	E. C. Whatley, Reynolds	
Telfair	F. R. Mann, Jr., McRae	D. B. McRae, McRae	Last Fri.
Thomas-Brooks	D. J. McKenzie, Thomasville	F. G. Osborne, Thomasville	Upon Call
Tift	T. L. Edmondson, Tifton	P. W. Lucas, Tifton	1st Mon.
Tri-County	F. T. Robbins, Hinesville	W. D. Fraser, Hinesville	2nd Tues.
Troup	G. A. McCrary, LaGrange	E. A. Prieto, LaGrange	
Upson	L. L. Allen, Jr., Thomaston	J. E. Mikell, Thomaston	
Walker-Catoosa-Dade	Gordon Hixson, Ft. Oglethorpe	W. D. Crawley, Rossville	
Walton	P. J. Enslen, Monroe	R. M. Tankesley, Monroe	4th Mon.
Ware	O. R. Wilson, Alma	J. W. Bickerstaff, Waycross	1st Tues.
Washington	M. W. Hurt, Sandersville	D. L. Holmes, Sandersville	
Wayne	R. A. Pumpelly, Jesup	E. L. Harrell, Jesup	2nd Mon.
Whitfield	A. N. Boozer, Dalton	Thomas Carey, Dalton	
Wilkes	C. E. Pollock, Washington	A. D. Duggan, Washington	2nd Tues.
Worth	F. L. McLean, Sylvester	R. T. Morgan, Sylvester	3rd Tues.

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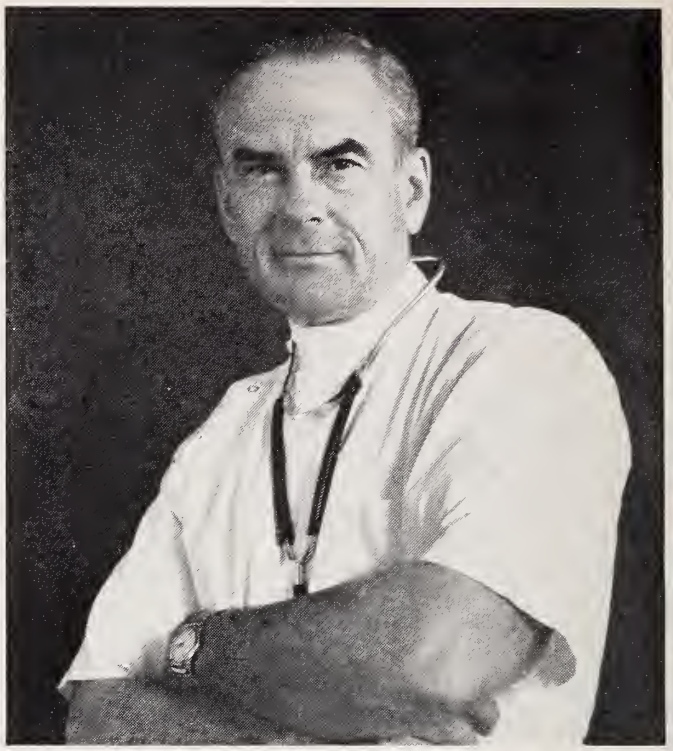

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JOURNAL OF THE MEDICAL ASSOCIATION Georgia
OCTOBER / 1968

HEALTH PLATFORMS

Democratic

The best of modern medical care should be made available to every American. We support efforts to overcome the remaining barriers of distance, poverty, ignorance, and discrimination that separate persons from adequate medical services.

During the last eight years of Democratic administrations, this nation has taken giant steps forward in assuring life and health for its citizens. In the years ahead, we Democrats are determined to take those final steps that are necessary to make certain that every American, regardless of economic status, shall live out his years without fear of the high costs of sickness.

Through a partnership of government and private enterprise we must develop new coordinated approaches to stem the rise in medical and drug costs without lowering the quality or availability of medical care. Out-of-hospital care, comprehensive group practice arrangements, increased availability of neighborhood health centers, and the greater use of sub-professional aides can all contribute to the lowering of medical costs.

We will raise the level of research in all fields of health, with special programs for development of the artificial heart and the heart transplant technique, development of drugs to treat and prevent the recurrence of heart diseases, expansion of current task forces in cancer research and the creation of new ones including cancer of the lung, determination of the factors in mental retardation and reduction of infant mortality, development of drugs to reduce the incidence of suicide and construction of health research facilities and hospitals.

We must build new medical, dental and medical service schools, and increase the capacity of existing ones, to train more doctors, dentists, nurses, and medical technicians.

Medical care should be extended to disabled beneficiaries under the Old Age, Survivors and Disability Insurance Act to the same extent and under the same system that such care is available to the aged.

Thousands of children die, or are handicapped for life, because their mothers did not receive proper pre-natal medical attention or because the infants were unattended in the critical first days of life. Maternal and child health centers, located and designed to serve the needs of the poor, and voluntary family planning information centers should be established throughout the country. Medicaid programs administered by the states should have uniform standards so that no mother or child is denied necessary health services. Finally, we urge consideration of a program comparable to Medicare to finance prenatal care for mothers and post-natal care for childred during the first year of life.

Republican

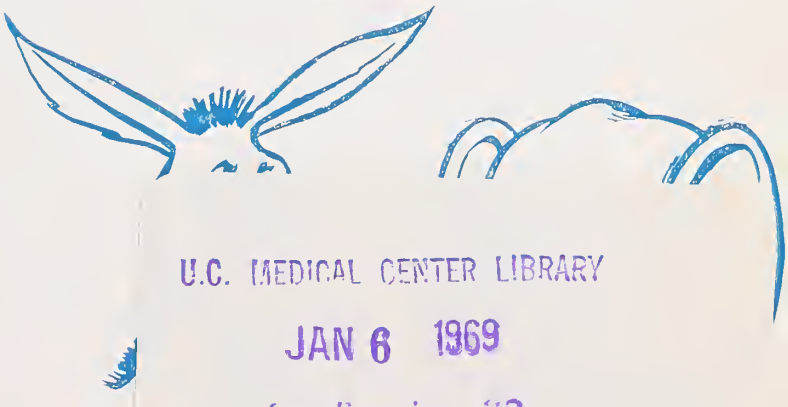
The inflation produced by the Johnson-Humphrey Administration has struck hardest in the area of health care. Hospital costs are rising 16 per cent a year—four times the national average of price increases.

We pledge to encourage the broadening of private health insurance plans, many of which cover hospital care only, and to review the operation of government hospital care programs in order to encourage more patients to utilize non-hospital facilities. Expansion of the number of doctors, nurses, and supporting staff to relieve shortages and spread the availability of health care services will have our support. We will foster the construction of additional hospitals and encourage regional hospital and health planning for the maximum development of facilities for medical and nursing care. We will also press for enactment of Republican-sponsored programs for financing of hospital modernization. New diagnostic methods and also preventive care to assure early detection of physical impairments, thus fostering good health and avoiding illnesses requiring hospitalization, will have our support.

Additionally, we will work with states and local communities to help assure improved services to the mentally ill within a community setting and will intensify research to develop better treatment methods. We will encourage extension of private health insurance to cover mental illness.

While believing no American should be denied adequate medical treatment, we will be diligent in protecting the traditional patient-doctor relationship and the integrity of the medical practitioner.

We are especially concerned with the difficult circumstances of thousands of handicapped citizens who daily encounter architectural barriers which they are physically unable to surmount. We will support programs to reduce and where possible to eliminate such barriers in the construction of federal building.



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(1) Siver, R. H.: CMD, *21*:109, September 1954. (2) Frykman, H. H.: Minn. Med., *38*:19-27, January 1955. (3) McGivney, J.: Tex. State Jour. Med., *51*:16-18, January 1955. (4) Quehl, T. M.: Jour. of Florida Acad. Gen. Prac., *15*:15-16, October 1965. (5) Weekes, D. J.: N.Y. State Jour. Med., *58*:2672-2673, August 1958. (6) Weekes, D. J.: EENT Digest, *25*:47-59, December 1963. (7) Abbott, P. L.: Jour. Oral Surg., Anes., & Hosp. Dental Serv., 310-312, July 1961. (8) Rapoport, L. and Levine, W. I.: Oral Surg., Oral Med. & Oral Path., *20*:591-593, November 1965.

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JOURNAL OF THE MEDICAL ASSOCIATION Georgia

Politics Without Doctors Is Bad Medicine

SENATOR PAUL FANNIN, *Republican, Arizona*

When the program committee asked me to talk about doctors and politics, I felt pleased, challenged and disturbed. Pleased at the opportunity to be with you, challenged by the problems of bringing the many factors of today's complex political picture into focus, and disturbed by the problems facing this nation and how I could objectively describe them without being classified as an alarmist.

Death From Within

Arnold Toynbee has pointed out that 19 of 21 civilizations have died from within and not by conquest from without. There were no bands playing and flags waving when these civilizations decayed. It happened slowly, in the quiet and dark when no one was aware.

Could this happen to us? To our families? To our way of life? Could this happen to America the beautiful?

It is happening—you need only to look around you.

You need only to read your morning paper or watch the evening news on television to see evidences of our rising crime rate, the hard-core unemployed, the jammed freeways, the polluted rivers, harbors and air. The problems are so omnipresent as to seem almost overwhelming. This is the year, 1968, in which we Americans will have to make up our minds what we want to do about these problems.

Liberty Is Not License

Human energy cannot operate effectively except when men are free to act and to be responsible for their actions. But liberty does not mean license; for no one has the right to infringe upon the rights of others. Certain restraints are necessary and they are provided in two ways:

First—legal restraints—laws administered by governmental agencies and enforced by proper police power.

Second—moral restraints—which depend on individual self-discipline, logical reasoning, good sportsmanship and a consideration for the rights of others.

What is happening to America? What is America's purpose to be? Do we have a purpose for all people at home and abroad—not to control the world but to do our part for freedom with the insistence that other nations do likewise?

Principles Canot Be Abandoned

I maintain that we cannot now abandon the principles that so many have fought and died for. Even though the struggle is difficult, the battle hard and

Presented at the General Assembly program, 114th Annual Session of the Medical Association of Georgia, Augusta, May 5, 1968.

unpopular, America the beautiful never came about because men shrank from doing their duty. We must stand up and be counted: Shrinking violets never produced stately oaks.

What is the attitude of American people? How highly is freedom esteemed in this land? Unfortunately we have a despicable group who claim freedoms' rights without living up to its responsibilities. Fortunately they are not the majority, or even a significant minority—but we are well aware of their presence. They assault all the senses—eyes, ears and nose.

Just a few days ago out in Arizona, a young man who lives his life in a wheel chair, faced down a group of these hippies.

Yes, we have hippies in Arizona. Our climate is so healthful that almost anything grows there. Anyway, this crippled young man, in spite of his difficulties, is working his way through the University of Arizona.

Hippies Forced to Listen

The hippies were carrying on a campus demonstration downing America when this agonized young fellow demanded to be heard. The hippies would not have listened except that the "straight" students—those who make up the vast majority of practically any American student body—insisted that he be given the right to speak. To the hippies, freedom of speech applies only to them.

He struggled to the front and courageously shamed them. He said, "I wish I could go to Viet Nam, but I can't. I'm a cripple. You people can," he continued, "but you won't. You won't fight. You won't even cut your hair," he said. "You look like a bunch of dogs. You say you want freedom. Unless you support the Constitution, defend your country and its system, all your freedoms, all your liberty will be taken away."

Who Pays the Bills?

Then he asked them one question: "Who pays the bills?" He waved the microphone and shouted again, "Who pays the bills? Not you cowards," he said.

This young man happens to pay his own bills. This young fellow who has held five scholarships and works and studies 18 hours a day put the finger on the problem that underlies all our domestic and international unrest when he asked the question, "Who pays the bills?"

In perhaps a little different way I think this is the question most Americans are asking today. They feel it in the frustrations and suppressed anger that leaps up when they see college and university officials who stand aside and wring their hands for a week before moving in on a bunch of student hoodlums.

Decent law-abiding citizens of every color are angered when rioting and looting are defended as expressions of grief. Deep down America gets mad when Washington keeps promising to do everything for everybody all the time. Americans want to know, "Who is going to pay the bill?"

I think just about everyone knows who the hippies, and the deadbeats, and the hangers-on expect to pay the bill. You—hard-working, patriotic Americans. Yes, you—with more taxes. All it will take to destroy America eventually is for more people to become "tax-eaters" than "tax-payers." Then we go down the drain.

Socialism Smothers Incentive

This is not simply idle speculation. We have seen the signs and gathered the warnings from Britain for years. I don't have to tell this group about the "brain drain." You are well aware that doctors and other highly motivated scientists have been fleeing the smothering socialized system. Recently the British government announced another cutback in the already meager medical program offered to the public.

Whenever there is a choice, productive people will not work under a system that provides them no incentive. We want and we must demand that America retain the freedoms that have given this nation world leadership.

Great Britain vs. Japan

In April Dr. Werner von Braun testified before the Astronautics and Space Sciences subcommittee and compared the differences between Great Britain and Japan since World War II. He pointed out that when Great Britain got rid of Churchill and shifted their priorities from industrial research and development programs to social programs, the net result has been, in the words of Dr. von Braun, "That the entire economy has lost so much steam it cannot produce a tax intake now even to finance the social programs."

On the other hand, Japan, with social problems just as pressing, solved them by concentrating on jobs through industrial and economic development. They started with transistor radios and now are coming up with sophisticated products that, according to Dr. von Braun, "Have almost cornered the world market." Last year more than 61 per cent of the radios sold in the United States came from overseas. As you know, medical instruments are

coming from Japan and other foreign countries in larger and larger quantities.

Potential Is Important

Dr. von Braun points out that shifting our priorities to immediate concerns may ignore potential development which will have far-reaching beneficial effects. He says comparing the space satellite for communications with the manned space program is like comparing an automobile with a baby. The auto is good for something right now—the baby represents a liability for many years, but presents much more potential than the auto which will be on the scrap heap in just a few years.

Priorities Must Be Determined

So we in the Congress face a very complex series of factors in trying to determine national priorities. In the end, however, Congress will be responsive to your expressed actions. Right now Congress is responding to the actions of a very vocal group of citizens. Congress and the administration are also responding to the apathy and indifference that plague many Americans who fail to express themselves, content to leave politics to the politicians.

I am a businessman. I know the pressures of the job that make you feel like you just can't take the time to be bothered with public affairs. It's quite natural for you to think that you can't take an active part in the political events that surround you, but let me say this: If you don't take part in politics, then the politicians will take you apart.

Threat of Labor Leaders

Recently George Meany made what he thought was a campaign film with President Johnson. The President sort of jolted George with his [later] announcement, but I think this statement by Mr. Meany, who is the president of the largest labor organization in America, is important. At the conclusion of the film he said: "Elections are not won in Washington. They are won back home."

Meany continued, "So I urge you to start now. Collect the cope dollars . . . make sure your members know the issues, know the voting record of the candidates, know who is a friend and who is not, and get out and vote on election day.

"In a very real sense, you, the leaders of the labor movement, will decide the 1968 election. I am confident you will do the job."

The job they will do will not be for your best interests or the best interest of this nation, not even, for the union member. For if they get their way, this nation will soon be socialized.

We are going to have to realize that giving the power of decision back to the people rather than surrendering it to political opportunists takes three things: It takes money, it takes time, it takes effort.

You have to speak out.

Recently, a Negro doctor in Washington, Dr. Tom Matthew, a surgeon who operates a hospital in New York—employing Negroes and giving them a chance to engage in productive employment—spoke out against the so-called "poor people's campaign." He decried the spending of money for what he called "Operation Overkill," and said the money spent there could provide 20,000 permanent jobs for the hard-core unemployed. I may not agree with everything Dr. Matthew says or does, but I think he's on the right track and I know he's right about speaking out. He also told the self-appointed professional "poverticians" this: "Our grandparents had a guaranteed annual income. They called it slavery."

Americans Must Defend Their System

I say it is the duty of everyone who makes his living and profits from our American system to defend and protect that system.

We must preserve the climate that fosters incentive in this nation. One of the great incentive givers is what I call "plus dollars."

"Plus dollars" have been a tremendous force for social good in this nation. These "plus dollars" are the dollars a man has left over after paying his bills and scrimping and saving; and they provide the money for new jobs, new business, new investment. When we take that away, we destroy one of the prime movers for prosperity and social well-being in the nation.

Why should we penalize the man who has tried to better himself; who has sweated through school or worked nights and weekends because he wanted to be something?

We are faced with legislation that intends to stifle initiative, and reward indolence.

Innovators Are Penalized

Striving for excellence, striving for perfection, trying to make it work better. These all result in what I like to describe as "brain acceleration," thinking hard. But today in our concern for the under-achiever we penalize the innovator. Unions push for featherbedding and demand employment that no longer is necessary, thus forcing up prices, decreasing demand and eventually exporting the job to a nation that can undersell us.

Our nation has been built on the concern for quality. Our products have outsold and outperformed because of this constant emphasis on doing it better, beating the competition.

However, we are presently faced with a legislative proposal which will, in my opinion, do more to un-

dermine our concern for quality and high standards than anything that has come down the pike in a long time. It is reverse discrimination.

EEOC Seeks Broader Powers

I'm talking about legislation to give broader enforcement powers to the Equal Employment Opportunity Commission.

This bill, if enacted into law, will mean that the government in Washington can control the hiring, firing and promotion possibilities of almost every worker in the nation. The sponsors say we must have this legislation to remove job discrimination.

I, too, hope that every vestige of discrimination will soon disappear, and that people will be judged on their individual merits—not on the basis of race, color, creed or national origin.

Much as I wish to have all prejudice and discrimination eliminated, however, I cannot in good conscience support what I consider unsound legislation no matter how appealing the title. If I vote on the basis of political expediency, emotionalism or fear, rather than on the basis of reason, on the merits of the provisions of the legislation under consideration, then I am not fulfilling my responsibilities as a member of the United States Senate.

This body, the Equal Employment Opportunity Commission, created by the 1964 Civil Rights Act, already has the power to witchhunt into every nook and cranny of American institutions and if it finds what it evaluates as a pattern of unfair discrimination, the Commission has the power to demand compliance or to get the Justice Department to file suit and prosecute. But now the EEOC wants its own enforcement powers—to be the accuser and the decider. It wants to be able to go into a business, or any establishment, like a hospital, for example, and say "You are discriminating; you must immediately cease and desist or you may be in contempt of the legal power of the court."

Employer Will Be Defenseless

As a practical matter, the employer will have very little to say in his defense. There are some provisions for appeal, but they are so ineffective in practice as to be inconsequential. In essence, the employer is denied his day in court.

Reverse Discrimination

This is not mere theory. The EEOC has already done such things as creating preferential promotion lists based strictly on color, requiring an employer to eliminate all forms of testing "not culturally validated," and hire or promote people who are recommended by such organizations as the NAACP or CORE, without regard to their skills or qualifications for the position.

These things are happening, and the EEOC has been able to make them stick in cases where the employer is a government contractor or recipient of Federal funds. This is making some men "more equal" than others.

This kind of legislation, carried out in the name of equalizing opportunity, may actually result in fewer job openings because we move from the realm of voluntarism and cooperation into coercion.

Hospitals Can Be Coerced

Most hospitals receive Federal funds of one kind or another, so they can be coerced too. But even for those few private institutions the EEOC apparently wants the right to tell you that you employ too many of one color, or too few of another on your staff of physicians, and they want to be able to enforce these illegal and arbitrary standards without regard to tests of qualification or skill. The medical profession must have the right to maintain high standards in patient treatment and no bureaucrat should have the power to jeopardize people's lives.

The EEOC has questioned airlines to see if pilots are the right color percentage wise. It has questioned the *New York Times* concerning the racial and national make-up of its writing and reporting staff.

For my part, I don't care about the color of my pilot, or my doctor's skin; I just want to know that he knows what he's doing. I want him to be in the position he is in because he deserves to be there, not because some desk jockey in Washington *thinks* he *ought* to be there.

Well, these are serious responsibilities. You can see that you have a large stake in them. In this present fight we have run across businessman after businessman who tells me "Go to it Paul, we're all for you. Fight that battle, but don't get me involved!"

I tell them, "You're already involved, right up to here, and you'd better not be so timid about fighting your own battle."

Physicians Must Speak Out

Will the doctors ever march on Washington? I certainly hope not; but at the same time you do have a responsibility to voice your opinions and your views in Washington.

Supreme Court Justice Hugo L. Black recently stated that law and order must prevail, and he upheld the police authorities in controlling the conduct of street marchers because, he said, "such conduct by its very nature tends to infringe upon the rights of others."

Mr. Justice Black said that ours is a government

in which reasoned decisions are made by public officials chosen in a way which the law provided. "Those laws do not provide that elected officials will act in response to preemptory demands of the leaders of tramping, singing, shouting, angry groups," Justice Black continued.

Limits to First Amendment

"I do not believe that the First Amendment grants a Constitutional right to engage in the conduct of picketing or demonstrating . . ." he said. "Marching back and forth, though utilized to communicate ideas, is not speech and therefore is not protected by the First Amendment."

Law and Order

We must have law and order in this nation.

There is a lesson to be drawn from what happened in Memphis and from what has been happening with increasing intensity throughout the nation in recent years. That is that mass protests, mass demonstrations, and mass marches and the like, whether labeled non-violent or otherwise, can only serve to encourage unrest and disorder, and to provoke violence and bloodshed. And in the end those who advocate such methods often become, themselves, the victims of the forces they themselves set in motion.

Opportunity Is Available

In any case, I know you have an opportunity to work for the men you think can best represent your philosophy. I know, because I have received this kind of help from doctors in my own State of Arizona.

I know from personal experience and observation what the medical profession—because of its leadership, and respect in the community—can do in politics for the benefit of good government.

ArMPAC, as it is called out there, was active in the elections of 1966. Doctors worked actively in my 1964 campaign.

There's another little wrinkle here that I might add. Doctors' wives have been of tremendous assistance in campaigns too, mine included—giving informal teas, or coffee klatches, or just plain talking to people. They've been a big help.

You have the opportunity, the machinery; I beg you to use it.

Guts and Guns

If America is to withstand these influences and trends I have described, there must be a renewal of the spirit of our forefathers; appreciation of the American way of life; strengthening of muscle and sinew and the character of the nation. America needs guts as well as guns.

Could many of the national wrongs that we suffer today be the result of our failure to train a strong citizenry? Have we grown up to believe in:

politics without principle;
pleasure without conscience;
knowledge without effort;
wealth without work;
business without morality;
science without humanity;
worship without sacrifice . . . ?

Sunshine Patriots

In the words of Thomas Paine, "These are the times that try men's souls. The summer soldier and the sunshine patriot will in this crisis, shrink from the service of his country; but he that stands it now deserves the love and thanks of man and woman. . . . The harder the conflict the more glorious the triumph. What we obtain too cheap, we esteem too lightly. Heaven knows how to put a proper price upon its goods; and it would be strange indeed, if so celestial an article as freedom should not be highly rated."

As American citizens who love freedom, we must return to a respect for national morality—respect for law and order. There is no other way of safety for us and for our posterity.

The hour is late; the time is short. We must begin now, in earnest, and invite God's blessing on our efforts.

The American's Creed

May I conclude my remarks with these words that need greater currency in the United States of America today than ever before. They are the words contained in the American's Creed.

"I believe in the United States of America as a government of the people, by the people, for the people; whose just powers are derived from the consent of the governed; a democracy in a republic; a sovereign nation of many sovereign states; a perfect union, one and inseparable; established upon those principles of freedom, equality, justice, and humanity for which American patriots sacrificed their lives and fortunes.

"I therefore believe it is my duty to my country to love it; to support its Constitution; to obey its laws; to respect its flag; and to defend it against all enemies."

The answer: speak up—work hard—think soundly.

U.S. Senate Office Building

The use of this technique in flexion tendon surgery and in Dupuytren's contracture is described and discussed.

The Use of the Multiple Angled Incision in Hand Surgery

JAMES L. BECTON, M.D. *and*
J. MACDONALD BURKHART, M.D., *Augusta*

THE IMPORTANCE OF properly oriented skin incisions in the hand has been pointed out by most authors writing on surgery of the hand. A great deal of care for the skin flaps and edges is stressed when reconstructive procedures on deeper structures are being done. A proper skin incision in the hand should meet the following requirements: (1) Provide full exposure of the deeper structure without excess pull on the skin with retractors; (2) provide exposure without having to work across a bridge of neurovascular structures; (3) should allow closure without excess tension; (4) resulting scar should not cause a flexion contracture.

The purpose of this paper is to present our experience with the use of the multiple angled or zig-zag incision on the flexor surface of the hands, as used in flexor tendon surgery and in Dupuytren's contracture.

Review of Literature

The classical correct and incorrect incisions in the hand were presented by Bunnell.[1] As the specialty of hand surgery has developed during the past thirty years, it has been learned that some of the so called correct incisions do not meet all the requirements of a "proper skin incision in the hand," and new ones have developed. A few of the "incorrect" ones have been found to be quite good under specific circumstances.

In the recent literature McGregor[2] gave an excellent discussion on the use of the Z-plasty in hand surgery. He points out that multiple Z-plasties at 60° angles and the size that will fit into adjoining phalangeal segments, usually work best. The 60° angle gives a 75 per cent increase in the longitudinal axis, with a corresponding shortening in the transverse axis that is acceptable by local tissues in the digit.

The Z-plasty is a very helpful technique in hand surgery; however, it must be precisely planned so that when the flaps have been interchanged, they do not twist too acutely on their base and jeopardize the blood supply to the small skin points.

The classical mid-lateral incision of the digits to expose the flexor tendon has been widely used. However, any extension of this incision into the palm requires that you work over a bridge of neurovascular structures at the base of the digit. Inadvertent damage to these structures may occur when using this incision.

Methods and Results

The multiple angled or zig-zag incision in the digit is done as illustrated in Figure 1. The angles of the

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Figure 1. The outline of the multiple angled or zig-zag incision is shown. The angles are at the anterior lateral edge of the digit.

incision are made at the volar lateral area at each flexion crease, and at the midpoint between the flexion crease. This multiple angled incision can be carried through the palm and up the forearm as needed. The flexor tendon can be exposed through its entire length, as is necessary for free tendon grafting. The neurovascular structures are beyond the incision and are not disturbed unless it is necessary to identify them.

The contracted fascia in Dupuytren's contracture can be dissected free and excised in both the finger and the palm through this continuous incision.

Closure of the skin is done by one corner suture at each corner and one suture midway between the corners. This loose closure allows any blood that may collect beneath the flap to escape into the dressing without the formation of a hematoma beneath the flap.

If there has been a contracture of the finger, as in Dupuytren's contracture, it may be helpful to increase the skin in the longitudinal axis by advancing the lateral skin. This is done by extending the angle of the incision and advancing the corresponding point of the skin flap. (Converting the V to a Y.) This allows the wider base of the flap to be advanced toward the midline as necessary, with resulting increase in the skin in the longitudinal axis (Figure 2).

Discussion

We have found this incision much easier than either the mid-lateral incision in the digit and the extension into the palm, as shown by Bunnell, or the longitudinal incision, with the formation of multiple Z-plasties, as suggested by McGregor. We now routinely use this incision when doing flexor tendon repair, advancement or free tendon grafting. It has also become our standard approach to limited fasciectomies in Dupuytren's contractures.

The multiple angled incision provides full exposure of the deep structures of the digit without excess pull on the skin with retractors. One towel clip in each flap will serve as a self retaining retractor. This incision provides exposure of the digit and palm without having to work across a bridge of neurovascular structures. It can be closed without excess tension. Tension on a small flap of skin, in a digit, may impair the blood supply to the points and result in necrosis at the suture line. This is more apt to oc-

Figure 2. The V is converted to a Y by extending the incision at the angles. The skin flap point is advanced at closure bringing the wider base of the flap to the midline of the digit.

cur when doing multiple, small Z-plasties. The scar resulting from this incision is usually small, soft and does not cause a flexion contracture. The multiple angled incision meets all the requirements of a "proper skin incision in the hand."

Summary

The technique of doing a multiple angled or zigzag incision in the digit is presented. We have found it to be the most useful incision when doing flexor tendon repair, free tendon grafting and fasciectomy for Dupuytren's contracture. It satisfies all the requirements of a proper skin incision in the hand.

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ISG RECOMMENDED FOR INFECTIOUS HEPATITIS

The use of immune serum globulin (ISG) for persons exposed or in danger of exposure to infectious hepatitis has been recommended by the U. S. Public Health Service. Dr. David J. Sencer, Director of the National Communicable Disease Center in Atlanta, Georgia, announced that the PHS Advisory Committee on Immunization Practices recommends ISG for close personal contacts of cases, for travelers to certain foreign areas, and for those exposed to a common source of infection.

No Vaccine Available

The Committee's recommendations point out that the agent that causes human infectious hepatitis has not yet been identified but is presumed to be a virus. No vaccine is available, but administration of immune serum globulin to exposed persons can afford a high degree of protection.

Of close personal contacts, the recommendations state, "There is good evidence that close personal contact. such as occurs among permanent or even temporary household residents, is important in spreading infectious hepatitis. Secondary attack rates are high for household contact, particularly children and teenagers."

"Conditions favoring transmission of infectious hepatitis exist in institutions such as prisons and facilities for the mentally retarded," the committee relates. When cases are reported in such institutions, the committee favors administration of ISG to their contacts.

Recommended for Travelers

ISG is also recommended for travelers who may be exposed to infected persons and to contaminated food and water in foreign areas where hepatitis is a major health problem. Individuals who reside abroad in areas where hepatitis is common should have immune serum globulin, repeated every six months.

When an item, such as food or water, is identified as a common source of infection of multiple hepatitis cases, administration of ISG should be considered for all those exposed to the source.

Not Recommended for All Groups

There are certain other groups for which routine administration of ISG is not indicated. These include:

School children and teachers who are contacts of a case. Although the highest incidence of hepatitis is among school-age children, contact at school is usually not an important means of transmitting the disease. If, however, epidemiologic study clearly shows that school or classroom contact is responsible for continued transmission of hepatitis, it is reasonable to administer ISG to individuals at risk.

Routine prophylactic administration of ISG to hospital personnel is not indicated. Emphasis should be placed on sound hygienic practices. However, for those accidentally inoculated with blood or serum of patients with hepatitis, ISG is recommended.

Routine administration of ISG is not indicated for persons in the usual office or factory situation exposed to a fellow worker with hepatitis.

The committee reemphasized an earlier recommendation concerning transfusion associated hepatitis. They point out that existing evidence provides no adequate basis for recommending that ISG be given routinely to recipients of blood transfusions.

Full text of the recommendations appears in the *Morbidity and Mortality Weekly Report* for the week ending August 3, released August 9 by the National Communicable Disease Center.

ORAL EXAMINATION

American Board of Anesthesiology
Atlanta
October 28-November 1

Human infection by this antibiotic sensitive member of the Actinomycete family has been reported only one time in the literature.

Dermatophilosis

THOMAS F. GOODMAN, M.D., *Augusta*

DERMATOPHILOSIS IS A mycotic cutaneous disease of animals. The disease has been reported in man, and has recently been reported in animals in the Atlanta area. It is caused by the organism Dermatophilus congolensis, a member of the Actinomycete family.

History

The disease was first reported by Van Saceghem in cattle in the Belgian Congo in 1915.[1] Since then the disease has been recognized in many species of wild and domestic animals throughout the world. The first case in the U. S. was recognized in cattle in Texas in 1961. Subsequently, it has been reported in New York, Iowa, Kansas, and in 1966, in the Atlanta area. The Atlanta outbreak involved 27 horses in four different herds. It was reported by Kaplan and Johnson.[2]

Animal Disease

The disease has been of considerable economic importance, causing, in its severe form in cattle, hair loss, secondary infection and severe ulceration resulting in weight loss. The most common lesions seen are crusts which often coalesce then fall away leaving denuded areas. Secondary bacterial infection is the most common complication. The disease has been given several names depending on the gross appearance of the infection and the distribution: Cutaneous Streptothricosis, Mycotic Dermatitis, Lumpy wool (in sheep), Strawberry foot rot, and Proliferative Dermatitis.

Human Disease

The disease in human beings has not been so well described. It has been reported only once in the literature. This report was by Dean et al.[3] in 1961. Four cases were reported. They had all contacted an infected deer. Two of the men were hunters who killed the deer, two were employees of the State Conservation Department who examined the deer.

These people, within 48 hours after being in contact with the deer, developed multiple pustules of the hands and forearms. These were described as small (2 x 5 mm) and non-painful, with serous or purulent material in the center and with a surrounding zone of erythema. No coalescence or spread was noted. The lesions all healed spontaneously without treatment in three to fourteen days. The organism Dermatophilus congolensis was isolated from the deer and from two of the four persons. One of the patients' lesions were heavily secondarily infected; the other patient had healed at the time of culture.

The Organism

Much of the work concerning microscopic description and classification has been done by Gordon.[4, 5] The organism is a member of the Actinomycete family and grows aerobically on Brain Heart Infusion

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agar at 37° C. It is also a facultative anaerobe. It can easily be seen in material from lesions (Figure 1).

Figure 1. Showing Dermatophilus congolensis organisms from bovine lesion. Gram stain, oil immersion lens. (Material courtesy of Wm. Kaplan, D.V.M.)

Various forms are seen using Wright, Gram, or Giemsa stain. These forms represent the various stages in the reproductive process. Gram positive, branching, fine filamentous mycelia are seen. These filaments increase in diameter, forming septae. Packets of 8-16 coccoid bodies form between septae. The mycelia divide along longitudinal and transverse planes to release the coccoid spores. Flagellae have been demonstrated and these spores are motile. The spores settle and form new hyphae, thus completing the life cycle. Culture requirements are somewhat complex,[6] bacterial overgrowth being the major problem. Animal inoculation has been helpful in obtaining more purified organisms for culture.

Experimental Animal Disease

A considerable amount of work has been done examining experimentally produced disease in animals by Roberts[7] and Kaplan.[2] Apparently the organisms are incapable of penetrating intact stratum corneum. Primary invasion is effected by first lightly scarifying the skin. Organisms have also been seen invading through hair follicles.

In experimental situations the following sequence of events is seen in histopathologic sections:

Day 1—Hyphae pierce the living epidermis. In the immediate area of the hyphae, nuclei lose their staining properties, cells shrink and appear to cornify. A dense granulocytic infiltrate begins to form in the upper dermis. Hyphal elements do not enter the dermis or the layer of granulocytic infiltrate.

Day 2-3—New epidermal layer forms beneath the granulocytic infiltrate, usually from hair follicles.

Day 4—The granulocytic infiltrate is now a crust and is cast off with cessation of the infection. In some cases hyphae penetrate the crust or may come from hair follicles to infect the newly formed epidermal layer.

All laboratory infections ran a course of from four to 12 days with spontaneous resolution.

We have not yet seen the disease in human beings. Diagnosis should be easy, provided we are aware of the disease and continue our practice of examining cutaneous pustular lesions with a stained smear. The organism is reported sensitive to penicillin, streptomycin, chlortetracycline, oxytetracycline and chloramphenicol.[8] We feel that should a case present itself of sufficient severity or chronicity to warrant treatment, penicillin or tetracycline systemically would be effective.

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Medical College of Georgia

AMA APPROVES DERMATOLOGY PROGRAM

For the first time in Georgia a state institution is authorized to train residents in the field of dermatology, and six physicians have been accepted into the training program.

The three year Dermatology Residency program at the Medical College of Georgia has received full approval by the American Medical Association. Facilities of the Eugene Talmadge Memorial Hospital, University Hospital, and the Veterans Administration Hospital are used for this work.

The Department of Dermatology, under the chairmanship of Dr. J. Graham Smith, was established in July, 1967. Since then, it has become an integral part of the Medical College's School of Medicine.

A comparison is made of the economic loss sustained by patients in each group.

Open Versus Closed Treatment of Femoral Shaft Fractures

C. WILLIAM BROWN, M.D., *Augusta*

FRACTURES OF THE FEMORAL SHAFT are a common occurrence in any busy orthopedic clinic.

This paper is an evaluation of closed fractures of the middle third of the femoral shaft in adults who have not incurred other injuries which would preclude their return to their previous employment. This excludes children, open fractures, and associated injuries such as spinal cord transsection. Most of these fractures were treated by Kuntscher cloverleaf intramedullary rodding. Hansen-Street nail and Rush pins are also used in a few cases.

Advantages of Intramedullary Fixation

The use of intramedullary fixation has certain great advantages such as shortened initial hospital stay, rapid mobilization of joints, early ambulation, early weight bearing and the ability to return to sedentary jobs while healing is still in progress. A report of 181 cases by P. J. R. Nichols in the *Journal of Bone and Joint Surgery,* 45B, stated that patients treated by intramedullary fixation returned to work an average of one month sooner than those treated by skeletal traction; however, 94 per cent of those treated in skeletal traction returned to duty compared to 87 per cent of those treated by open reduction.

Intramedullary fixation is not without complications as we all know. Non-union may occur, but the most serious complication is infection. At a recent Tennessee State Meeting, the Campbell Clinic, in a report of 600 cases of intramedullary fixation reported a six per cent infection rate, and in the *Journal of Trauma,* July, 1967 Dr. Jack Wickstrom reported a six per cent infection rate in 298 cases.

Economic Loss

Most of our patients are unskilled and do heavy manual labor. In our clinics we have been impressed with the long term follow-up required of those which had osteomyelitis as a result of open reduction. Not only do they require repeated hospital admissions for drainage, sequestrectomy and closed wound irrigation with antibiotics, but many of them are unable to return to work during these recurring episodes which may go on for years.

Osteomyelitis of the femur represents an enormous economic loss to patients.

This report is a comparison of the economic loss to those patients treated by the closed method to those treated by open reduction. Cases presented in this series were all patients treated at Talmadge Hospital from 1957 to 1964. The total number of femurs is 44 in 38 patients.

Four Methods of Treatment

In order to evaluate properly the cost of hospitalization and loss of economic income, it was

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necessary to divide the patients into four groups:

1. Those treated in balanced traction who had no other associated injuries which would delay their recovery.
2. Those treated with intramedullary fixation who did not become infected and had no other associated injuries.
3. Those treated with intramedullary fixation who had no other significant injuries, but developed osteomyelitis secondary to open reduction.
4. Those who had associated injuries which would tend to delay their recovery.

The time required to return to full activity was selected as the time at which the patient had no resultant disability which would prevent him from returning to his previous employment. Some of these figures are estimates as will be explained later.

One case from each category will be presented.

Category 1. This 23-year-old white female sustained bilateral femoral fractures in an automobile accident. She was five months pregnant at that time. Bilateral skeletal traction applied. Traction removed at two months and she delivered a 2500 gm. viable infant. The left leg was maintained in a posterior splint and traction reapplied to the right leg. Spica cast was applied one week after delivery. The patient went on to satisfactory healing of both fractures.

Category 2. Intramedullary fixation without associated injuries or infection. This 23-year-old colored male was shot in the right femur with a 38 caliber pistol. Four weeks after his injury a Hansen-Street rod was inserted. His fracture healed primarily and he returned to work for three years when there was a sudden onset of pain in his right knee nine weeks prior to admission to Talmadge Hospital. At the time of admission he was unable to extend his knee. The rod was removed; he regained full knee motion and returned to work.

Category 3. This 33-year-old white male sustained a fracture of both femurs in a truck accident in 1956. Kuntscher nails were inserted bilaterally during the same operative procedure within three days after his injury. At that time the patient stated that there were open contusions and lacerations of the skin. Both femurs became infected. The nails were later removed and when he was first admitted to Talmadge Hospital several months post-injury he had obvious infected non-unions of both femurs. After multiple drainage, perfusion and spica casting procedures, he eventually healed both fractures and was ambulatory in long leg braces when he fell in April 1959 and refractured the left femur. He again had drainage, perfusions and spica casting with healing of the fracture. He required a long leg brace initially, but now walks with a cane and works daily in a grocery store as a clerk. He has a fused left knee and only 30 degrees of motion on the right. There has been occasional drainage over the past few years.

Category 4. This 57-year-old white male was hit by a car while walking on the side of the road. He sustained a fracture of his right femur, as well as left distal tibia and fibula, right radius and ulna as well as a laceration of his transverse colon with multiple bladder contusions. The fractures were splinted and skeletal traction applied to the femur. Because of abdominal distension and rectal bleeding, abdominal exploration was done, the colon laceration repaired and the bleeding point ligated. His tibial fracture was treated in a long leg cast. The forearm had an open reduction and bone grafting. The femoral shaft was treated in balanced traction until stable.

Comparative Statistics

In Category 1 (balanced traction), the statistics show:

Number of hospital days: 49;
Cost at $40 per day: $1,960;
Time to return to full activity: ten months;
Loss of income at $60 per week: $2,400;
Total economic loss: $4,360.

All patients in Category 1 healed primarily and none had significant residual contractures.

Category 2 (intramedullary fixation without associated injuries or infection):

Average number of hospital days: 25;
Cost: $1,000;
Time to return to full activity: 11 months;
Income loss: $2,640;
Total economic loss: $3,640.

The length of hospital stay is probably greater than that on most private services since we usually do not operate on these patients for 10 to 14 days, at which time the fracture is bone grafted and the patient is kept in the hospital until the sutures are removed. The time to return to full activity may also be a little excessive when compared to the population average, since so many of our patients are engaged in heavy work which would tend to delay their return to full employment.

Category 3 (intramedullary fixation without associated injuries, but who developed osteomyelitis):

Average number of hospital days: 83;
Cost of hospitalization at $40 per day: $3,320;
Time to return to full activity: 37 months;
Average loss of income at $60 per week: $8,880;
Total economic loss $12,200.

For Category 3 both average time out of work and

average income loss are estimates and are probably low since almost none of these patients has returned to work. The charts on all these patients are current and all come regularly to the clinic. I have not attempted to project the ultimate economic loss which may be incurred by this group, but have chosen merely to accept the situation as it now stands. Five out of eight knees on the infected side had less than 45 degrees knee motion and the other three had 90 degrees or more, but none had more than 125 degrees.

Category 4 (femoral shaft fractures with associated injuries):

Average hospital stay: 63 days;
Cost at $40 per day: $2,520;
Return to full activity: 13 months;
Average loss of income at $60 per week: $3,360;
Total economic loss: $5,880.

Associated injuries of this type which were not permanent did not have any long delay in return to full activity. There were ten patients in this group which suggests that trauma severe enough to fracture a femur frequently causes other injuries such as rupture of viscera or other fractures.

There were 38 patients with 44 fractured femurs who met the requirements for inclusion in this study. Eight femurs were infected as a result of open reduction. Six of the eight patients were patients who were referred to Talmadge Hospital after initial treatment elsewhere. The hospitalization time was twice as long as for those treated in balanced traction. The time required to return to full activity is three times as long and in most cases they have not yet returned to work. Residual contractures, especially of the knees, are present in every case with infection. This was not a significant factor in non-infected cases. No attempt at evaluation of disability was made, but it was noted to be a persistent factor in infected cases. The patients who were successfully treated by intramedullary fixation did not return to full activity any faster than those treated in balanced traction and frequently returned for a second hospital admission for removal of the metal. The patients with associated injuries returned to full activity rapidly when their course was not complicated by femoral shaft infection.

Conclusions

In conclusion, (1) patients with closed fractures, treated in balanced traction do not become infected with the exception of pin tracts. (2) With infection the average economic loss exceeded $12,200 in hospital bills and loss of income. This does not include physicians' fees. (3) The patients successfully treated by intramedullary fixation returned to full activity about the same time as those treated in skeletal traction with a difference in cost of about $700. (4) Residual disability was not a significant factor so long as the infection was not present. Knee motion was severely restricted in five out of eight infected femurs.

Medical College of Georgia

SEND MEDICAL JOURNALS TO FOREIGN COLLEAGUES

The doctors of the U.S.A. are being asked to send their medical journals—after they have read them—to colleagues overseas (Asia, Latin America, and Africa) who wish to have access to current medical literature but, either because of currency regulations or actual cost involved, cannot themselves subscribe to medical periodicals. We can supply you with the name, address, and medical specialty of doctors in these areas who would be happy to receive these much wanted journals, particularly speciality journals, which you will mail direct to your overseas colleague.

"Doctor-to-Doctor"

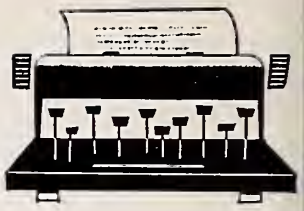
This is a direct "Doctor-to-Doctor" program which is being sponsored by the American Medical Association with the collaboration of The World Medical Association to help alleviate the lack of current medical publications and to further international good will. Your cooperation in this program will be greatly appreciated and your contact with these colleagues in other countries, we can assure you, will prove very gratifying.

If you wish to participate in this program, send your name, address, and titles of journals you will contribute to Doctor-to-Doctor Program, The World Medical Association, 10 Columbus Circle, New York, New York 10019.

MELLON TRUST AWARDS GRANT TO EMORY

The Emory University School of Medicine is one of thirty private medical schools in the United States to share in grants totaling $10 million. The grants were awarded by the Richard King Mellon Charitable Trusts to expand and strengthen medical teaching. Under the terms of the grant, Emory will receive $50,000 for the next five years, for a total of $250,000.

EDITORIALS



Propanolol

For some years the beta adrenergic blockers, particularly propanolol (Inderal) have been used in the treatment of a variety of cardio-vascular disorders, including arrhythmias, angina, hypertension, pheochromocytoma, and idiopathic hypertrophic subaortic stenosis (IHSS).

The action of propanolol is largely that of blocking the beta action of catecholamines locally produced by activity of sympathetic nerve fiber endings supplying heart tissues, or catecholamines distantly produced as in adrenal medullary stimulation by excitement or in pheochromocytoma. Although pharmacologically antagonistic to isuprel, it is chemically similar, and apparently has the action of a dummy key, which will enter the receptor site, preventing the active catecholamine from using this site to produce its beta adrenergic activity.

Acts on the S-A Node

It acts on the S-A node to slow its rate (negative chronotropic activity) and to prevent an increase in rate from sympathetic stimulation resulting from exercise, excitement, etc. This action is useful in the treatment of angina and the prevention of sinus tachycardia in the induction of anesthesia, pheochromocytoma, etc.

It decreases the excitability of ectopic sites, tending to reduce atrial or ventricular premature contractions and increases the refractory period of the myocardium, which may revert such arrhythmias as PAT.

It increases the refractory period of the S-A and A-V nodes, and like digitalis acts rapidly and effectively to decrease the ventricular rate in atrial flutter of fibrillation.

Weakens Muscular Contractions

It diminishes the strength of contraction of the myocardial fibers (negative ionotropic action). This is helpful in the treatment of IHSS; by weakening the muscular contraction in the subaortic area the obstruction is lessened and the left ventricle—aortic gradient is reduced.

The less forceful myocardial contraction after propanolol may be helpful in angina since less oxygen is required, and possibly also there is better flow through the small arteries in the heart wall when contraction is less forceful. In essential or renal hypertension some reduction of blood pressure usually occurs, due to decreased cardiac output rather than any decrease in peripheral resistance.

Clinical Usefulness

Numerous studies have been and are being carried out to try to determine just how clinically useful this drug is. It is undoubtedly useful in IHSS.[1] It is certainly one of the useful agents available for reducing premature contractions and reverting PAT.[2] It is said to be the drug of choice[3] in PAT with block associated with digitalis toxicity. It may lessen the frequency of attacks in patients with recurrent bouts of ventricular tachycardia,[4] but is dangerous in the treatment of such an

attack because of hypotension. It is effective in slowing the ventricular rate in atrial flutter and fibrillation, but does not revert these arrhythmias. It can be helpful in the management of pheochromocytoma and in slowing sinus tachycardia from various causes. Its effect in hypertension is rather slight with blood pressure reductions averaging in the 5-8 per cent range, but possibly it could have a use here in conjunction with other antihypertensives. It seems to help some patients with angina. By preventing the heart from reacting to both the positive ionotropic and chronotropic stimuli of excitement, exercise, etc., the heart theoretically is able to avoid increased needs for oxygen which its arteries are poorly equipped to supply.

Some investigators differentiate between the angina of excitement or exposure to cold, and the angina of effort. In the first, the body has no need for the increased cardiac output, whereas in effort the increased output may prevent poor oxygenation of various tissues, including perhaps the myocardium. With angina of excitement, a beta blocker should be useful; with that of effort where one might say that the legs are walking but the heart is sitting down, there may be some disadvantages. In clinical studies to date some have found that only one in ten angina patients is benefitted,[5] some that around 80 per cent are helped by propanolol,[6] as judged by less pain, improved exercise tolerance, and less EKG changes during exercise.[7] Short or long acting nitrates have been thought to potentiate these beneficial effects.

Some Adverse Effects

It should be recognized that propanolol can also have serious adverse effects. It may cause bronchospasm and is generally contraindicated in asthmatic patients and chronic lung disease. Its effect in diminishing conduction through the A-V node and in diminishing ectopic excitability make its use dangerous in second and third degree block. Its negative ionotropic effect generally contraindicates its use in congestive failure where further decrease in the strength of myocardial contraction may be fatal. Its effect is potentiated in those recently on such catecholamine-depleting drugs as reserpine. Also there may be such effects as nausea, weakness, fainting, sweating, rashes, and diarrhea. With intravenous use intravenous isuprel should be available which will largely counteract its effects.

Conclusions

Therefore, although this drug is a useful one, it should be used with considerable respect. Certainly it has no place in the usual angina patient who responds well to reasonable restriction of activity and occasional nitroglycerine. Nor is it the drug of choice at present in previously untreated atrial fibrillation with rapid ventricular rate, which will usually respond so well to safer measures. Nevertheless it is a very interesting and useful addition to the physician's armamentarium in the cardiovascular field.

Grant Wilmer, M.D.

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3. *Am. J. Cardiology* 18:415, 1966.
4. *Am. J. Cardiology* 20:22, 1967.
5. *Am. J. Cardiology* 21:11, 1968.
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7. *Circulation* 38:250, 1968.

Proposed Mental Health Legislation

(The legislative proposals enumerated below have not been presented to or considered by the Medical Association of Georgia. Accordingly, they do not, at this point, represent the views of MAG. Rather, they represent viewpoints arrived at through joint meetings of representatives of the Georgia Department of Public Health and the Georgia Mental Health Association, and are presented in the JMAG as a service to its members and those interested in mental health legislation).

ADVANCES IN PSYCHIATRY in recent years make it necessary to change the laws relating to the mentally ill. It has been recognized by lawyers and physicians that admission to a mental health facility should be based as much as possible on medical considerations. Patients are encouraged to come voluntarily to hospitals as soon as possible after symptoms are noted.

For some time the undersigned, representing the Georgia Psychiatric Association, along with Dr. J. Frank Walker, representing the Medical Association of Georgia, have been working with two groups under the aegis of the State Health Department and the Georgia Mental Health Association to update these laws. It is anticipated that the following items will be introduced for consideration by the 1968 Georgia Legislature.

Recommended Proposals

(1) Clarification of *voluntary admission procedures.* In the opinion of the writer, this should also include provision for "informal admission," wherein the patient goes directly to the hospital rather than having to go through the formalities of filling out a form in a county health department which might be located some distance from the hospital.

(2) Creation of *emergency admission procedures.* Instead of sending acutely disturbed patients to jail, this provision will allow any hospital to accept and keep patients for 72 hours while appropriate acute evaluative and treatment procedures can be carried out. This would be done upon the signature of two physicians, one of whom could be the representative of the admitting hospital. It is expected that this statute would have a provision rendering the signing physician immune to prosecution except in the case of malice.

(3) The *involuntary admission procedure* would be changed to one that is basically medical, with certification by two physicians, but with legal protection for the patient spelled out so that court hearing *may be* obtained if desired by the patient or family.

(4) Allowing individuals sent to State hospital by a court to remain in the hospital after expiration of their sentence if this is deemed advisable by the hospital superintendent. This would apply to individuals who become 21 and are no longer under the jurisdiction of the juvenile court and adults who are serving

prison sentences and subsequently are found to be psychotic. Thereafter, treatment and civil rights would be the same as for any other involuntary patient.

(5) Setting up standards and procedures for *licensing day-care centers* for the retarded. If this statute is not enacted, we will have the prospect of many such helpless individuals left in inadequate and potentially dangerous surroundings.

There will also probably be an attempt to license "psychodramatists" or other pseudo-scientific opportunists who treat the mentally ill. (Proposed legislation last year would have required little beyond an undergraduate college degree or "its equivalent.") Despite the difficulty in finding capable, trained professionals in the accepted mental health disciplines, we must not let the untrained, self-seeking, and self-appointed "experts" foist themselves upon the public. At the very least they will create mischief; at their worst much suffering and possibly death.

Since our legislative friends are by virtue of their own backgrounds and experience largely unaware of the issues discussed, they will be turning to members of the medical profession for enlightenment and understanding. It would be most helpful if we can give them clear-cut and medically sound reasons when they do come to us.

Sheldon B. Cohen, M.D.

Labor's Open Secret

APPEARING BELOW IS A verbatim account of a news item appearing in the *AFL-CIO News,* under dateline, Washington, D. C., May 13, 1968.

The *News* is not our favorite source of information on matters relating to the cost of health care. Be that as it may, we must assume that pronouncements from "big labor's" Executive Council, appearing in its own press, accurately reflect its views, and do, in fact, give a tip-off as to the union's future intentions.

"Suggestions," as their pronouncements are benignly referred to in this article, have a way of becoming bedrock policy the instant they are adopted, and generally signal the beginning of massive lobbying to legislate the wishes of the bosses.

Pontificating from the star chambers of the nation's most politically powerful union, the Executive Council has, by its "suggestions," clearly indicated that it advocates far more rigid Federal control of the medical profession than anything thus far put forth. Promotion of comprehensive group practice prepayment plans smacks of closed panel medicine, and subtle inferences by the high priest of labor, that fee-for-service produces both low quality and high cost is not lost.

Fixed-Fee Schedule

Equally disturbing to anyone not accustomed to the shrill voice of expediency is "suggestion" number 3, which advocates a negotiated fixed-fee schedule for all physicians participating in Federal programs. The shotgun wedding of medical service and hospitalization, neatly tucked away in *manifesto* number 6, gives rise to the belief that labor is suspicious of all physicians not employed on a salary.

If, during recent years, there has been any doubt that organized labor's top

echelon has feverishly worked for the bureaucratic capture of the medical profession, none should exist any longer. What heretofore might have been an open secret is now a matter of public record.

For the most part, labor cannot achieve these goals except by legislation. To do this, it must first capture the legislative process. In short, it must elect enough of its own people to compel by law that which would be rejected by common sense.

It is time for medicine to close ranks for a solid, massive, immovable front against such radical, far ranging and long lasting innovations.

The following is excerpted from a statement on medical costs adopted by the AFL-CIO Executive Council May 13, 1968 in Washington.

We suggest immediate consideration of the following specific steps for reducing the cost while maintaining the quality of medical care:

1. Promotion of the fastest possible growth of comprehensive group practice prepayment plans which have proven their ability to provide comprehensive health services of high quality at substantial savings over fee-for-service, solo practice.

2. Encouragement of more efficient utilization of the supply of doctors, nurses and other health personnel, including adequate opportunities for training and promotion at all levels.

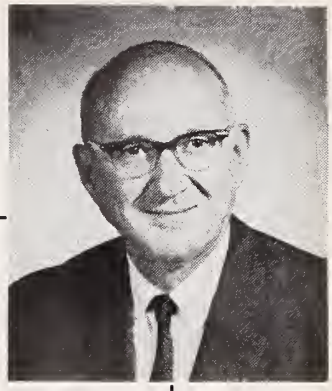
3. Payment of medical care on a capitation basis, that is, an actuarially determined amount paid at periodic intervals covering total health care. Capitation payments should cover not only physician services but hospitalization, extended care and home health services as well. Under such a system of payment physicians would have an incentive to practice preventive medicine and thus keep patients well out of the hospital. A minimum program would be to provide for a negotiated fee schedule for all physicians participating in Federal programs. Changes in such reimbursement should be negotiated, not determined unilaterally by physicians.

4. Because the decisions of physicians have such a great impact on hospital costs, to the maximum extent possible physicians, especially hospital-based physicians and the heads of various medical departments, should be made administratively responsible to the hospital.

5. Reimbursement of hospitals on the basis of average cost for all hospitals in similar circumstances thereby rewarding the efficient and penalizing the inefficient. Alternatively, they might be reimbursed on the basis of a negotiated rate per patient.

6. The artificial distinction in medicine between the method of financing physician services and hospitalization should be eliminated by establishing a single system of financing both, requiring no additional out-of-pocket payment from beneficiaries.

7. The Food and Drug Administration should have the authority to evaluate the relative effectiveness of drugs. On the basis of such objective scientific and clinical information, this information should be made available to physicians and hospitals in an official governmental or government approved generic name formulary which would indicate the most appropriate drug for different diseases. Hospitals and other providers of care should be required to use this formulary or an equally effective one for their own use under appropriate Federal standards. They should be required to purchase quality drugs listed in the formulary on a generic name basis and by competitive bid.



ODDS AND ENDS

It was my pleasure, and indeed a privilege to attend the meeting of the Organization of State Medical Association Presidents prior to the A.M.A. Annual Communications Conference in August. When the State presidents, presidents-elect, and immediate past presidents got together in groups to discuss and coordinate (if possible) their problems, the outcome was most enlightening. It is amazing when one stops to realize that the problems confronting one section of the county are not isolated (apparently I am not a cosmopolite).

Similarity of Problems

Many aspects of medicine and medically related problems involving education (all forms), practice (all types), government control, medical organization, and medical opposition to socialized medicine were thrown open and discussed. This type of forum at the time of the A.M.A. Communications Conference was instituted by Dr. Kressenberg, past president of Tennessee Medical Association. Congratulations to him on a job well done. You would be surprised at the basic similarity of problems from one State to another.

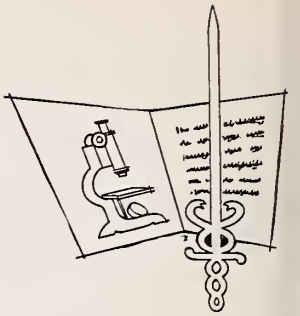
Closer Liaison with SAMA

Having emphasized the need of organizational improvement and closer liaison with Student American Medical Association, thinking these were indigenous to Georgia, it was quite eye-opening to me to find these situations almost nationwide. Most of the State executives were of the same accord. Of course, many had their local variations with intensity of problems.

To cover the whole scope would require an equivalent of a large volume of congressional records. But to be brief, it might behoove you to study all the ramifications of a few problems that your Medical Association of Georgia encounters: organization, Office of Economic Opportunity, Title XIX, medical education, Student American Medical Association, Osteopaths, Federal controls, plus a few others. Think about all of the aspects! And don't forget these are your problems to control and iron out, or have a foreign or socialistic method shoved down your throat.

Charles R. Andrews Jr. M.D.

Charles R. Andrews, Jr.
President, Medical Association of Georgia



STATEWIDE CERVICAL CANCER SCREENING SERVICE: INTERIM REPORT

JACK M. LANDRUM, ***Atlanta***

CANCER OF THE CERVIX is recognized to be three to five times as frequent in the lower socio-economic group of women who have frequent pregnancies and start at an early age. These are the patients who make up the caseload in the local public health department clinics.

Statewide Screening Program Established

In February 1967, with the approval of the State Board of Health, the Georgia Department of Public Health through local health departments, established a statewide cervical cancer screening service for early detection of cervical carcinoma utilizing the Papanicolaou screening test (Ref. J.M.A. Ga., July 1967, Vol. 56). The basic operational plan of the service is directed to the patients in the regular clinic caseload of the local health departments. The goal of this service is to increase casefindings in cervical carcinoma at the earliest, curable stage of the disease and thus decrease the morbidity and mortality in women due to carcinoma of the cervix (see Table 1).

Wide Acceptance of Program

As of 30 June 1968, 140 of the 159 counties in Georgia were providing cervical cancer screening services through local health department clinics to eligible women. The program expanded rapidly and was well received and favorably acknowledged by all groups interested and concerned. Pap smear kits and fixative spray for use in local health department clinics are supplied by the Georgia Department of

TABLE I
DEATHS FROM UTERINE CANCER, GEORGIA

Type	1964	1965	1966	1967
Cancer of Cervix	260	228	209	200
Cancer of Uterine Body	27	40	43	25
Cancer Uterus, Unspecified	104	94	89	71

Health Program Representative, Maternal Health Service, Georgia Department of Public Health.

TABLE II

PATIENTS WITH CLASS III PAP SMEARS

	Feb-Dec., 1967	Jan-June, 1968
Total Patients	94	73
Follow-up incomplete	16	44
Follow-up complete	78	29
Benign	50	20
Malignant	28	9
Pre-invasive Carcinoma	23	8
Radiation	1	0
Major Surgery	17	6
Minor Surgery	5	2
Invasive Carcinoma	5	1
Radiation	1	0
Major Surgery	4	1

Public Health. Thirty-one pathologists representing 26 laboratories in the State have been reading smears sent to them by health departments. The assignment of health departments to these pathologists was made on an estimation of clinic load as equitably as possible. The contributions of time and assistance on the part of these pathologists as well as clinicians have been the key to the success of the service. Without their help this important casefinding method would not be possible.

From the beginning of the program in 1967 through 30 June 1968, 18,830 Pap smears were performed in local health department clinics throughout the State. This interim report will present the results of this service in two segments; the first from February through December, 1967 and the second from January through June 1968.

In 1967, 10,115 Pap smears were done and reported as follows:

Class I	8,591	98.10 per cent negative
Class II	1,332	
Class III	104	1.25 per cent suspicious and positive
Class IV	21	
Class V	1	
Unsatisfactory	66	0.65 per cent

Classes III, IV, and V combined total 126, but represented 116 individual women due to repeat smears included in the grand total.

TABLE III

PATIENTS WITH CLASSES IV AND V PAP SMEARS

	Feb.-Dec., 1967	Jan-June, 1968
Total Patients	22	12
Follow-up incomplete	1	10
Follow-up complete	21	2
Benign	10	0
Malignant	11	2
Pre-invasive Carcinoma	7	2
Radiation	0	0
Major Surgery	6	2
Minor Surgery	1	0
Invasive Carcinoma	4	0
Radiation	1	0
Major Surgery	3	0

From January through June, 1968, 8,715 Pap smears were done and reported as follows:

Class I	7,573	98.28 per cent negative
Class II	987	
Class III	83	1.03 per cent suspicious and positive
Class IV	10	
Class V	2	
Unsatisfactory	60	0.69 per cent

Classes III, IV, and V combined total 95, but represent 85 individual patients.

Although early casefinding with referral for diagnosis and treatment as indicated, is the primary goal of the service, the above tables give a better picture of the overall results to date in patient care (Tables II and III).

In the past six months there have been 86 per cent as many screened as in the first year of the service. The average monthly screening is now approximatly 1,500.

Pre-Invasive Carcinomas Detected

The significance of this report lies in the number of pre-invasive carcinomas detected, whereas prior to the institution of the service, referrals had been made on the basis of clinical symptoms and physical findings alone and the malignancy had advanced to stages where the 5-year survival was less than 50 per cent. Of the 50 cases found, 40 were pre-invasive (age range 20-45) and ten were invasive carcinoma (age range 17-50). Thirty were referred to state-aid tumor clinics, 19 were referred to private physicians and one to an Army hospital, for treatment.

Expanded Educational Program

Under development at the present time is an expanded educational program which will include two film strips on cervical cancer screening. The first will be directed to the general public and the other will be available to medical and paramedical personnel. An information pamphlet, "DO YOU KNOW?", was produced early in 1967 and is available in quantities for distribution.

47 Trinity Ave.

CLINICAL STUDY IS SET ON EWING'S SARCOMA

The cooperation of physicians is requested in the referral of patients with Ewing's Sarcoma for a continuing study being conducted by the Radiation Branch of the National Cancer Institute at the Clinical Center, National Institutes of Health, Bethesda, Maryland.

Patients who have received no treatment are preferred, but selected patients with previous therapy will also be accepted for admission as inpatients. Upon completion of their studies, patients will be returned to the care of the referring physician, who will receive a summary of findings.

Physicians interested in having their patients considered for admission to this study may write or telephone: Ralph E. Johnson, M.D., Clinical Center, Room B1B-41B, National Institutes of Health, Bethesda, Maryland 20014. Telephone: 496-5457 (Area Code 301).

THE CERVICAL VENOUS HUM

JOSEPH E. HARDISON, M.D., *Atlanta*

THE CERVICAL VENOUS HUM is a continuous roaring or musical noise which may be heard and felt over one or both internal jugular veins at the base of the neck. It is more common and usually louder on the right. The hum is best detected using light pressure with the bell of the stethoscope with the patient in the sitting position and many be accentuated by having the patient turn his head away from the side of auscultation. Cervical venous hums are often loudest during cardiac diastole, are obliterated by compression of the ipsilateral internal jugular vein and by having the patient perform the valsalva maneuver, and occasionally by having the patient lie down. If the hum is loud, it may be heard in the second left or right intercostal space and thus be confused with patent ductus arteriosus or other conditions. Compression of the internal jugular vein will obliterate the "murmur" if it is due to a venous hum.

More Common Among Children

Cervical venous hums are usually present in normal children but tend to disappear during adulthood. The presence of a cervical venous hum in the adult may be of no significance but should alert the physician to the possibility of the existence of a hyperdynamic circulatory state. Anemia, thyrotoxicosis, and pregnancy are usually associated with cervical venous hums. The "bruit" heard over the thyroid gland in thyrotoxicosis is in almost every instance a venous hum. In addition, the absence of a venous hum in the presence of thyroid enlargement is strong evidence against the diagnosis of thyrotoxicosis.

Cervical venous hums may also be present in patients with intracranial arteriovenous malformations that produce increased cerebral blood flow. Therefore, patients who present with migraine-like headaches, a seizure disorder, a history of subarachnoid hemorrhage or "stroke" at a young age, or a complaint of a noise in their head should be examined closely for the presence of a cervical venous hum and cranial or orbital bruits.

Veterans Administration Hospital and
Emory University School of Medicine

Prepared at the request of the Committee on Professional Education of the Georgia Heart Association.

COMMITTEE ON MATERNAL & INFANT WELFARE: REPORT OF THE PERINATAL SUBCOMMITTEE

THE PERINATAL DEATH RATE in Georgia for the years 1956-60 was 41.0 per 1000 total births. This placed our State in 48th place among the 50 States, exceeded only by Alabama and Mississippi. During the period 1961-65, the Georgia perinatal mortality rate fell to 37.8 per 1000, which moved us to 45th place, exceeded by Alabama, Mississippi, New York, Vermont and Virginia. Though this represents some slight improvement, our high perinatal mortality rate still points toward major unsolved problems in reproductive care and newborn care in Georgia.

Approximately one year ago the Perinatal Mortality and Morbidity Subcommittee of the Maternal and Infant Welfare Committee, Medical Association of Georgia was reconstituted after an interval of almost ten years. The Subcommittee was charged by the Committee Chairman, Dr. Eugene Griffin, with the task of exploring ways in which fetal and neonatal mortality may be reduced in the State of Georgia. Since that time the Subcommittee, chaired by Dr. Malcolm G. Freeman, has met on a number of occasions and is developing a series of specific proposals to promote broader understanding of perinatal problems and to reduce perinatal loss to the least possible number.

Confidential Medical Report

The Subcommittee is in the process of composing a new Confidential Medical Report which should become a part of each birth certificate or fetal death certificate. With data on complications of pregnancy, labor and delivery from every delivery in the State, a continuing analysis of reproductive problems and their relationship to perinatal mortalities can be made.

Correlation of Birth Certificates and Infant Death Certificates

To analyze the relationship between neonatal deaths and complications of pregnancy, labor and delivery, it will be necessary to institute a system whereby each death certificate for children under one year of age can be matched with the corresponding birth certificate. It is hoped that support can be found to send a copy of the death certificate for each infant to the physician who delivered the child, the hospital of delivery, and/or the local health department. This would facilitate more adequate local perinatal mortality studies, as well as stimulate interest in such mortalities and their obstetric antecedents.

Local Perinatal Mortality Committees

Several months ago the Subcommittee sent out a questionnaire to all licensed hospitals with bassinets in the State. The questionnaire was designed to find out how many hospitals knew what their perinatal losses had been and how many had functioning committees to study perinatal mortalities. Seventy of 165 hospitals have replied to the questionnaire. Active perinatal mortality committees have been functioning in many of the largest hospitals and several additional

hospitals were stimulated to begin such studies. In many hospitals medical record committees or committees of the whole staff review perinatal mortality cases. Many hospitals have too small a delivery service or insufficient personnel to staff a committee.

The Perinatal Subcommittee has been able to identify a number of high risk counties and hopes to correlate available perinatal committees and personnel with adjacent areas of greatest need. In addition we hope to standardize definitions and classification of causes of death so that individual committees throughout the State may compare problems and results.

Malcolm G. Freeman, M.D., Chairman
Grady Memorial Hospital, Atlanta

EARLY DETECTION CAN CONTROL GLAUCOMA

Glaucoma, the second greatest cause of blindness in the United States, accounts for nearly 14 per cent of all loss of sight. Glaucoma in its most common form can destroy vision slowly and painlessly, sometimes without giving any warning signs or symptoms to its victim until most of his sight is gone.

Glaucoma is a disease characterized by an increase in fluid pressure within the eye. The front portion of the eye between the lens and the cornea holds a clear, watery liquid called the aqueous. Continuously throughout a human lifetime, aqueous is produced within this tiny chamber, flows through it to help nourish the cornea, and then drains through a minute natural canal. For reasons not yet completely understood by science, this drainage canal may become blocked.

If this happens, the aqueous flow backs up and begins to exert pressure within the eye. This pressure is transmitted to the retina which contains sensitive nerve cells and fibers that relay light stimuli through the optic nerve to the brain. The increased pressure can cause the destruction of these cells; with each cell destroyed, a portion of the field of vision is lost forever. Eventually the entire field of vision is lost.

The Georgia Society for the Prevention of Blindness estimates that more than 1,702,000 American adults 35 years and older have glaucoma, and half of them are not aware of it.

Irreversible Blindness

Blindness from glaucoma is irreversible; that is, vision once destroyed by glaucoma can never be restored. Early detection of the disease, therefore, is vital to preventing blindness. Regular eye examinations for adults 35 years and over every two years is recommended. Heredity has been shown as a significant factor in glaucoma and a yearly examination is suggested for all those in whose family there have been cases of glaucoma.

Glaucoma Screening Project

A principal tool of the Society for teaching the public about glaucoma and encouraging periodic eye examinations is the glaucoma screening project. The Society sponsors such screenings throughout the State with the aid of local medical societies, civic and volunteer groups. The tests conducted are not substitutes for complete eye examinations, but the screening sessions do turn up many cases of previously unsuspected glaucoma.

—Prepared by the Georgia Society for the Prevention of Blindness

PMA ISSUES STATEMENT ON DRUG REPORT

The following statement can be attributed to C. Joseph Stetler, President, Pharmaceutical Manufacturers Association, in connection with the report given August 20 by Dr. Christopher M. Martin of Georgetown University in Minneapolis at the Fall Meeting of the American Society for Pharmacology and Experimental Therapeutics:

"The studies by Dr. Martin and his research team, showing how different versions of the same drug behave differently in man, provide further proof of the scientific fact that these differences can be significant in patients.

"Only recently, the Pharmaceutical Manufacturers Association published a bibliography of 'Biopharmaceutics' which listed no less than 501 citations. Of these, 221 are concerned with in vivo human studies.

"Clearly, there is no evidence to indicate that all formulations of the same drug are equivalent. From all the evidence that has been developed to date, as Dr. Martin's studies point out, quite the opposite may be true.

"For this reason, the importance attached to the prescribing and dispensing of products made by reputable manufacturers with high standards of manufacturing and quality control, cannot be overstated. There is no substitute for excellence."

THE ASSOCIATION

NEW MEMBERS

Berenson, Morton P., M.D. Active—Richmond	2208 Glendale Road Augusta, Georgia 30904
Prawlins, George McV., M.D. Active—Chattahoochee	101 North Road Snellville, Georgia 30278
Ward, William T., Jr., M.D. Active—DeKalb	231 E. Ponce de Leon Ave. Decatur, Georgia 30030

SOCIETIES

New officers of the **Tift County Medical Society** include Tom Edmondson, president; Robley Smith, vice-president; and Paul Lucas, secretary-treasurer.

At the regular meeting of the **DeKalb County Medical Society** held August 19, members heard M. C. Adair, M.D. of Washington, Georgia speak on "A Look at Medical Ethics."

A joint meeting of the **Cobb County Medical Society** and Auxiliary was held at The Squires on October 1. Corbett Thigpen, M.D., Augusta psychiatrist, and author of "Three Faces of Eve," spoke to members on returning to the real American way of life.

Members of the **Seventh District Medical Society** were the guests of the **Polk County Medical Society** at a joint meeting on September 4 in Cedartown. Speakers on the program included Carl A. Smith of Atlanta; Hamilton S. Dixon of Rome, and Fred L. Allman of Atlanta.

PERSONALS

First District

The Georgia Radiological Society installed **Harry H. McGee, Jr.,** of Savannah as president for 1968. **Mark Brown** of Augusta was named president-elect.

Also chosen as officers of the Society were **William H. Somers** of Macon, vice president; **Hershel U. Martin** of Dalton, treasurer; **Neal F. Yeomans** of Waycross, ACR Councilor and **Donald Rooney** of Marietta, alternate.

Leon Curry has joined with **Robert L. Pence** and **Robert S. Robinson** to form a three-man partnership for the practice of medicine in Netter.

Second District

The Tifton *News-Examiner* printed a tribute to **Charles Zimmerman** at the time of his retirement from the practice of medicine. The tribute, on behalf of the people with whom he worked, appeared originally in the Tift General Hospital News, and praised Dr. Zimmerman's church work, civic activity and the "zest he brought to medicine."

James W. Merritt and **Hinton J. Merritt** held an open house in their new clinic which has opened in Colquitt. The building boasts two examining rooms for each doctor, a laboratory, emergency room, nursing station, doctor's lounge and library, twin waiting rooms and offices for the receptionist and bookkeeper.

Fifth District

Nanette Wenger of Atlanta recently lectured to the Florida Academy of General Practice at a meeting held in the Bahamas. She discussed the "Rehabilitation of Pediatric and Adolescent Cardiac Patients." Dr. Wenger also chaired three luncheon panels on the subject of myocardial infarction.

At a conference of the American Thoracic Society and the National Tuberculosis and Respiratory Disease Association, Drs. **P. N. Symbas, William D. Logan, Jr., Charles R. Hatcher, Jr.,** and **Osler Abbott** presented a paper on "An Appraisal of Pulmonary Sequestration: Special Emphasis on Unusual Manifestations."

Atlanta psychiatrist **Rives Chalmers** lectured to the Eighth Annual Southeastern School of Alcohol Studies at the University of Georgia. Speaking before a group of physicians, nurses, social workers, educators, law enforcement personnel, clergymen, and labor and industrial leaders, Dr. Chalmers noted that successful treatment can sometimes be obtained by using tactics of "apparent total failure."

W. A. Bootle, Jr. has joined The Radiology Associates at Macon Hospital it was announced recently. Dr. Bootle will practice radiology and nuclear medicine.

Samuel A. Wilkins, Jr. has been installed as president of the James Ewing Society for 1968-69. Dr. Wilkins is associated with the Emory University School of Medicine.

At the recent meeting of the International College of Surgeons, **John R. Lewis, Jr.** of Atlanta was one of six United States physicians to present a scientific paper. Dr. Lewis spoke on the "Reconstruction of Female and Male Breast."

J. Frank Walker of Atlanta, Chairman of the Board of Chancellors of the American College of Radiology presented a paper before a meeting of the West Virginia Radiological Society. The occasion was the 101st Annual Meeting of the Society, held at The Greenbrier Hotel in August.

Research on the diagnosis of breast cancer is being carried on at Emory University School of Medicine by **Robert L. Egan.** Dr. Egan, quoted in *JAMA*, says he is "personally convinced that radiography of breast biopsies is indispensable to the pathological diagnosis of very early breast cancers."

Seventh District

The National Tuberculosis and Respiratory Disease Association recently awarded a pin for fifty years of

voluntary service to **Carl C. Aven** of Marietta. Dr. Aven is one of only 14 individuals to receive this honor. The official presentation will take place at the Georgia TB Association meeting in Rome in November.

John Atha, of Rockmart, discussed the abuse of drugs at a recent meeting of Kiwanians in Rockmart. He pointed out that in addition to obvious misuse of drugs such as LSD, that the use of tranquilizers and "pep" pills affects the average public and causes the problems that most general practitioners handle.

Trend Industries has announced the appointment of **Lester J. Martens** of Rome as medical consultant. Dr. Martens assumed the new position on August 1.

Louis A. Williams of Ringgold, has terminated his medical practice in that area to assume a new position with the Medical Department of the Atlas Chemical Company in Chattanooga.

Eighth District

R. A. Pumpelly of Jesup was one of many physicians from the Southeast who attended the Federal Aviation Medical Seminar in Atlanta in August. Following this meeting, Dr. Pumpelly and **Fred Harper,** also of Jesup, attended the Pediatric and Obstetrics Seminar of the American Academy of General Practice in Daytona Beach.

"Boss of the Year" award goes to **Ralph Roberts** of Fitzgerald who gave his office staff a week's cruise to Nassau, all expenses paid. Dr. Roberts said the trip was a bonus for the years of service given by his staff.

Ninth District

Larry Morris has begun the practice of pediatrics in association with **Ben Gilbert** in Gainesville.

Tenth District

The Walton County Board of Commissioners, Roads and Revenues has announced that **J. Howard Barton** of Social Circle has been named to serve on the Walton County Hospital Board of Authority.

DEATHS

Seth Eugene Latham

Seth Eugene Latham, staff physician at Emory University Hospital, died July 18 at the age of 43.

A resident of Atlanta for six years, Dr. Latham was also a consultant in obstetrics and gynecology at Emory University School of Medicine. In addition, he was a member of the Fulton County Medical Society, the American Academy of General Practice, and the Medical Association of Georgia.

Surviving Dr. Latham are his wife Dr. Elizabeth Boykin Latham; a daughter, Margaret Elizabeth Latham; and three sons, Seth E. Latham, Jr., Richard Boykin Latham and William de Saussure Latham, all of Atlanta.

Henry C. Standard, Jr.

A Washington, Georgia physician, Henry C. (Mickey) Standard, Jr., 33, died July 25 of injuries received in an automobile accident.

A graduate of Emory University and the Medical College of Georgia, Dr. Standard was a staff physician at DeKalb General Hospital in Decatur. He was a member of the Fulton County Medical Society, the Medical Association of Georgia, and the American Medical Association.

Survivors include his wife, the former Marcia Crawford; two sons, Henry C. Standard, III, and Scott Crawford Standard, both of Atlanta; and his parents, Mr. and Mrs. Henry C. Standard, Sr. of Washington.

Cleveland D. Whelchel

Cleveland D. Whelchel, of Gainesville, died July 25 at the age of 78, following a long illness.

A native of Hall County, Dr. Whelchel attended Gainesville public schools and Atlanta College of Physicians and Surgeons (now Emory). He graduated from the University of Maryland, and was associated with Downey, Whelchel and Burns in the old Downey Hospital, and was the first chief of staff at Hall County Hospital. He was a fellow in the American College of Surgeons, and a member of the Medical Association of Georgia.

Surviving are his daughter, Mrs. Mary Whelchel Morris of Wilmington, Delaware; a brother, W. P. Whelchel of Gainesville, and two grandsons, Cleve Morris and Johnny Morris, both of Wilmington, Delaware.

RESEARCH BEGINS ON HISTORY OF MEDICINE IN GEORGIA

Research which is expected to result in the publication of a multi-volume history of medicine in Georgia has begun at the University of Georgia under the direction of Professors Horace Montgomery and H. H. Cunningham. It is contemplated that in the course of this project one of the nation's more important centers for research in medical history might be developed and constitute an ongoing research activity in Athens. Several significant studies undertaken by graduate students in history at the University are already in progress.

Physicians' Cooperation Needed

The interest and cooperation of physicians is urgently needed, and it is hoped that all will lend their support to the project. It is particularly necessary that individual physicians and medical societies work with the historians in assisting them to obtain the essential materials for a comprehensive treatment of Georgia medicine. Such materials would be housed at the University of Georgia and become available for research there.

Inquiries and suggestions may be directed to Professors Montgomery and Cunningham at Le Conte Hall, University of Georgia 30601.

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OCTOBER 20-26

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THE MONTH IN WASHINGTON

President Johnson signed into law the Health Manpower Act of 1968 which extends for two years, until June 30, 1971, and expands the Federal programs of aid to medical and allied health schools.

Other health legislation enacted into law: (1) establishes a National Eye Institute as part of the National Institutes of Health; (2) requires Federal buildings to provide easy access to the handicapped; (3) authorizes standards to prevent gas lines from leaking and exploding.

Schools of pharmacy and veterinary medicine were made eligible for the first time.

Authorizations for Funds

Money authorizations for schools in the new law:

Medical and other health professions—construction grants, $395 million; institutional support, $285 million; scholarships, $32.8 million; student loans, $70 million; total, $782.8 million.

Nursing—construction, $60 million; institutional support, $75 million; traineeships, $34 million; scholarships, $50 million; student loans, $41 million; total, $260 million.

Allied health (fiscal 1970 only)—construction, $10 million; institutional support, $20 million; traineeships, $5 million; new methods, $4.5 million; total, $39.5 million.

Public health—graduate training, $20.5 million; traineeships, $24 million; total, $44.5 million.

Health research construction, $50 million.

GOP Emphasizes Private Medicine

Both the Democratic and Republican 1968 national campaign platforms cited the importance of the role of private enterprise in the development of government health programs. The GOP placed greater emphasis on private medicine than the Democratic party did.

"While believing no American should be denied adequate medical treatment, we will be diligent in protecting the traditional patient-doctor relationship and the integrity of the medical practitioner," the Republican plank said.

The Republican platform also pledged "to encourage the broadening of private health insurance plans," including extension to cover mental illness.

Democrats Stress Lower Costs

"Through a partnership of government and private enterprise, we must develop new coordinated approaches to stem the rise in medical costs without lowering the quality or availability of medicare care," the Democratic platform said.

Without being specific, the Democrats indicated support for universal government health insurance or, at the least, wide expansion of medicare or medicaid (or both). Boasting of "giant steps" in the past eight years "in assuring life and health for its citizens," their platform said: "We Democrats are determined to take those final steps that are necessary to make certain that every American, regardless of economic status, shall live out his years without fear of the high costs of sickness."

The Democratic health plank also said medical

costs could be lowered by more out-of-hospital care, comprehensive group practice arrangements, increased availability of neighborhood health centers, and the greater use of sub-professional aides.

The Republican platform said "inflation produced by the Johnson-Humphrey Administration" was a major factor in the increases in health care costs.

American Medical Association spokesmen appeared before the platform committees of both parties at pre-convention hearings. Dr. Donald E. Wood, Indianapolis, Ind., chairman of the AMA's Council on Legislative Activities, testified at the Republican hearing; Dr. John R. Kernodle, Burlington, N.C., a member of the AMA Board of Trustees, at the Democratic. Their statements were the same.

AMA Statement to Parties

The AMA statement expressed hope that the next Federal Administration, whether it be Democratic or Republican, "will provide men and women in medicine, and those engaged in the allied sciences, the opportunity to think and work in a free atmosphere to pursue their common goal of a better and more healthful life for everyone."

The AMA emphasized the desirability of health programs being partnerships among private enterprise and Federal, State and local governments. The AMA pledged its support to such cooperative programs for mental illness, infant mortality, occupational health and safety, and education of physicians and allied health personnel.

Proposes Physician in the Cabinet

Concerning health care costs, the AMA said:

"We believe that programs to increase the production of medical and other health personnel can be cooperatively and effectively undertaken. We are further firmly convinced that we can and must work toward a health in the inflationary spiral, and toward a productive use of tax dollars expended in the health area. New and old tax supported programs in the health field should be critically evaluated so that while the best health care is attained, overlapping, waste and unnecessary programming are avoided. In this regard, we recommend the establishment of a cabinet-level Department of Health, headed by a physician as Secretary, with overall responsibility for all Federal health programs, so that maximum effectiveness may be attained."

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CALENDAR OF MEETINGS

October 25-26—AMA Residency Review Committee for Anesthesiology and the Council on Medical Education Field Staff, Department of Graduate Medical Education, Marriott Motor Hotel, Atlanta.

October 28-November 1—Family Practice Symposium, The Medical College of Georgia, Augusta.

October 29-November 1—American Society of Tropical Medicine and Hygiene, Biltmore Hotel, Atlanta.

November 11-13—Seminar on Advances and New Directions in Diagnosis of Cancer, Medical College of Ga., Augusta.

November 15-16—Georgia Academy of General Practice, DeSoto Hilton Hotel, Savannah, Ga.

December 5-8—American Rheumatism Association, Regency-Hyatt House, Atlanta.

February 18-22, 1969—American College of Radiology, Regency-Hyatt House, Atlanta.

February 23-26—Atlanta Graduate Medical Assembly, Regency-Hyatt House, Atlanta.

March 14-15—American Burn Association, Regency-Hyatt House, Atlanta.

March 27-29—Southern Society of Anesthesiologists, Marriott Motor Hotel, Atlanta.

National

October 14-18—American College of Surgeons, Dennis Hotel, Atlantic City, N.J.

October 17-19—Association of American Physicians and Surgeons, Roosevelt Hotel, New Orleans, La.

October 17-19—Leukemia Society of America, Americana Hotel, Bal Harbour, Fla.

October 19-23—Annual Meeting of American Society of Anesthesiologists, Washington Hilton Hotel, Washington, D.C.

October 19-24—American Academy of Pediatrics, Palmer House, Chicago, Ill.

October 20-21—American Association of Poison Control Centers, Palmer House, Chicago, Ill.

October 24-26—American Rhinologic Society, Ambassador Hotel, Chicago, Ill.

October 25-26—American Society of Ophthalmologic and Otolaryngologic Allergy, Palmer House, Chicago, Ill.

October 27-28—American Social Health Association, Annual Leadership Conference, Hotel Biltmore, New York, N.Y.

October 27-30—American College of Gastroenterology, Statler-Hilton Hotel, Boston, Mass.

October 27-31—American Dental Association, Fontainebleau and Eden Roc Hotels, Miami Beach, Fla.

October 27-November 1—American Academy of Ophthalmology and Otolaryngology, Palmer House, Chicago, Ill.

October 27-November 1—American Society of Plastic and Reconstructive Surgeons, Roosevelt Hotel, New Orleans, La.

October 28-29—Conference on Evaluation of Safety of Cosmetics, Marriott Twin Bridges Motor Hotel, Washington, D.C.

October 28-30—Association of Life Insurance Medical Directors of America, Chase-Park Plaza Hotel, St. Louis, Mo.

October 28-31—American Association of Blood Banks, Shoreham Hotel, Washington, D.C.

October 31—American Association for Study of Liver Disease, Sheraton-Chicago Hotel, Chicago, Ill.

November 1-4—Association of American Medical Colleges, Shamrock Hilton, Houston, Tex.

November 2—Society for the Scientific Study of Sex, Barbizon Plaza Hotel, New York, N.Y.

November 4-7—American Institute of Ultrasonics in Medicine, Monteleone Hotel, New Orleans, La.

November 7-8—American Academy of Compensation Medicine (Meeting on Medical and Surgical Problems in Workmen's Compensation), New York University Medical Center, New York, N.Y.

November 7-9—American Society of Anesthesiologists, Conference on Respiratory Therapy, Statler-Hilton Hotel, Washington, D.C.

November 7-9—Second Annual Conference on "Today's Hospital Problems: An Interdisciplinary Approach," Tides Hotel and Bath Club, Redington Beach, Fla.

November 7-9—American Society of Cytology, Cleveland-Sheraton Hotel, Cleveland, Ohio.

November 7-10—Association of Clinical Scientists, Shoreham Hotel, Washington, D.C.

November 10-14—American School Health Association, Pick-Fort Shelby, Detroit, Mich.

November 10-15—American Association for Inhalation Therapy, Shamrock Hilton Hotel, Houston, Tex.

November 11-13—American Association for Clinical Immunology and Allergy, Las Vegas, Nev.

November 11-15—American Public Health Association, Cobo Hall, Detroit, Mich.

November 11-15—American College of Preventive Medicine, Detroit, Mich.

November 14-16—Southern Thoracic Surgical Association, Puerto Rico-Sheraton, San Juan, P.R.

November 17-20—APhA Academy of Pharmaceutical Sciences, Statler Hilton Hotel, Washington, D.C.

November 18-21—Southern Medical Association, The Rivergate, New Orleans, La.

November 19-20—Council on Arteriosclerosis, Balmoral Hotel, Bal Harbour, Fla.

November 20-22—National Society for the Prevention of Blindness, Inc., Roosevelt Hotel, New York, N.Y.

November 21-26—American Heart Association, Americana Hotel, Bal Harbour, Fla.

November 22-23—Southern Society for Pediatric Research, Roosevelt Hotel, New Orleans, La.

November 29-30—National Federation of Catholic Physicians' Guilds, Miami Beach, Fla.

November 30—AMA National Conference on Community Health Planning, Statler Hilton Hotel, Miami Beach, Fla.

December 1-4—American Medical Association, Clinical Convention, Miami Beach, Fla.

December 1—AMA National Conference on Medical Aspects of Sports, Hotel Deauville, Miami Beach, Fla.

December 1-6—Radiological Society of America, Chicago, Ill.

December 1-7—International Congress of Pediatrics, Mexico City, Mex.

December 4-7—American Medical Women's Association, Statler-Hilton Hotel, Boston, Mass.

December 6-7—American Federation for Clinical Research, Somerset Hotel, Boston, Mass.

December 7-12—American Academy of Dermatology, Palmer House, Chicago, Ill.

December 9-11—Southern Surgical Association, Boca Raton Hotel and Club, Boca Raton, Fla.

December 10-14—American Academy for Cerebral Palsy, Americana Hotel, Bal Harbour, Fla.

December 13-15—American Academy of Psychoanalysis, Royal Orleans Hotel, New Orleans, La.

December 20-22—American Psychoanalytic Association, Waldorf Astoria Hotel, New York, N.Y.

1969

January 12-17—Society of Cryosurgery, Hilton Plaza, Miami Beach, Fla.

January 17-18—American Society for Surgery of the Hand, Americana Hotel, New York, N.Y.

January 18-23—American Academy of Orthopaedic Surgeons, Americana Hotel, New York, N.Y.

January 23-24—Southern Society for Clinical Investigation, Jung Hotel, New Orleans, La.

January 31-February 2—Southern Radiological Conference, Grand Hotel, Point Clear, Ala.

NASSAU MEETING PLANNED FOR RADIOLOGISTS

The American College of Radiology will sponsor a conference and tour in Nassau, in the Bahama Islands, February 22-28, 1969. The conference follows the College's annual meeting in Atlanta February 18-22, 1969.

The conference sessions will be held February 24-27 at the Nassau Beach Hotel near Nassau on New Providence Island. The group will leave from Atlanta at the end of the annual meeting and return to the U.S. on February 28. A three-day extension to Freeport on Grand Bahama Island is also offered.

Arrangements for the conference are handled for the College by Group Travel Services of Kansas City. The basic rate for the Nassau trip is $326 per person for accommodations, breakfasts and dinners, parties and extras and round trip travel from Miami to Nassau. The rate for travel from Atlanta and return to Miami is $359 per person. This rate requires double occupancy of hotel rooms. The extension to Freeport is $128 per person extra, and reservations will be made at the Lucayan Beach Hotel.

Reservations should be made to Group Travel Services, 3545 Broadway, Kansas City, Missouri. A deposit of $50 per person for the Nassau trip and an additional $25 per person for the Freeport extension is required with reservations.

SPINAL CORD INJURIES ARE SUBJECT OF COURSE

The Committee on Injuries of the American Academy of Orthopaedic Surgeons will sponsor a three-day postgraduate course on the spinal cord injured patient December 6-8, 1968, at the Americana Hotel, Miami Beach, Florida. Invited to attend are orthopaedic surgeons, neurosurgeons, physiatrists, urologists, and rehabilitation personnel. The course will be held in cooperation with the University of Miami School of Medicine and the Committee on Rehabilitation of the American Academy of Orthopaedic Surgeons.

The faculty of 35 physicians and therapists includes members of the school's staff and guest lecturers from 13 states and the District of Columbia. Subjects covered will include surgical procedures, rehabilitation potentials of the paraplegic and quadriplegic, current research, pain and spasticity management, emergency room care, GU infections, occupational and physical therapy, and the social problem of the spinal cord patient.

Registration fee for physicians is $125 and for nonphysician therapists, $50. Residents and interns will be admitted for $25 fee by letter from the Chief of Service at their hospital.

For information, contact is Augusto Sarmiento, M.D., University of Miami School of Medicine, P. O. Box 875, Biscayne Annex, Miami, Florida 33152.

SCIENTIFIC SESSIONS PLANNED FOR AMA CLINICAL CONVENTION

Scientific sessions of wide medical interest are planned for morning and afternoon Monday through Wednesday (Dec. 2-4) at the American Medical Association's 22nd Clinical Convention in Miami Beach, Fla.

Morning topics on December 2 include the anemias, thrombophlebitis, and obstetrics. The afternoon program includes discussion of white cell disorders and diseases of the lymph nodes, management of claudication, cerebral ischemia due to neck vessel occlusion, and gynecology.

Tuesday, December 3, the topics are cardiology, gastrointestinal diseases, proctology, and—in the afternoon—new approaches in cardiology, bacterial skin infections, and the skin and sunlight.

Discussions on sex will be held Wednesday morning, December 4, to include such topics as marital problems, changing sex values, preadolescent and adolescent sex education, and sex and the senior citizen. Hypertension and the kidney also will be studied at the morning session. Wednesday afternoon's topics include pulmonary diseases, respiratory ills in children, and more on the kidney.

Scientific sessions will be held in Miami Beach Convention Hall. Total registration is expected to be about 10,000, including 4,500 physicians; 300 medical students, nurses, and members of allied medical professions; 800 industrial exhibitors; and 4,400 guests of physicians and exhibitors.

The October 21 issue of *The Journal of the American Medical Association* will carry the Scientific Program for the Clinical Convention.

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PHYSICIAN WANTED—For Outpatient and Admitting service in this 572-bed General Medical and Surgical Hospital. Affiliated with Emory Medical School. Salary dependent upon qualifications—range $16,946-$23,075 per year. Licensure in any State. Excellent vacation, retirement, health and life insurance plans and other benefits. An Equal Opportunity Employer. Write Chief of Staff, Veterans Administration Hospital, P.O. Box 29457, Atlanta, Georgia, 30329, or phone Area Code 404, 634-5171, ext. 235.

PEDIATRICIAN—Coordinator, Child and School Health Services with the Fulton County Department of Public Health. Salary range: Monthly—$1,172-$1,490; Yearly—$14,064-$17,880. Qualifications: Licensed to practice medicine in Georgia. Experience in pediatrics and graduate degree in public health desirable. May consider a well-qualified person on a part-time basis. For more details and to apply, contact: Fulton County Civil Service Board, Room 310, County Administration Building, 165 Central Avenue, S.W., Atlanta, Ga. 30303. Phone: 572-2383.

OFFICE SPACE FOR RENT—Good location in Northwest Georgia for internist or one interested in general medicine. Five other physicians in building. Will introduce and help get practice established. Reply to Box 615, c/o JMAG, 938 Peachtree Street, N.E., Atlanta, Ga. 30309.

FOR SALE: A. O. Binocular microscope; Thermofax copy machine; Picker vertical fluoroscope (30 MA; 88 KVP), equipped with accessories for chest X-ray; Sanborn Visette EKG machine. Write Martha C. Gordy, M.D., Memorial Medical Center, Savannah, Ga.

ATLANTA DOCTOR'S OFFICE FOR RENT: Strickler South Building, 1285 Peachtree Street, N.E. Waiting room; nurse's station: private office; two treatment rooms; $200 per month, including all utilities and services. For arrangements to inspect, contact Sam Massell, Jr., exclusive agent, Allan-Grayson Realty Company, 40 Pryor Street, S.W., Atlanta, Ga., or phone 521-1694.

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GEORGIA MEDICAL SCHOOLS RECEIVE AMA-ERF GRANTS

Grants totaling $948,907 are being distributed this year to medical schools throughout the nation as a result of contributions made to the American Medical Association Education and Research Foundation for the year 1967. The contributions were from physicians and the Woman's Auxiliary to the AMA-ERF program.

Emory University School of Medicine will receive $5,167, and the Medical College of Georgia will receive $4,996.

OURNAL
THE MEDICAL
SSOCIATION of Georgia
NOVEMBER / 1968

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■ Literature on indications and dosage available on request.

■ No side effects have been reported, even when massive doses (25 tablets per day) were administered.

■ Supplied in bottles of twenty-five 3,000 unit tablets.

(In vivo measurement of Lutrexin on contracting uterine muscle of the guinea pig.)

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Cover

This electron photomicrograph of the new Hong Kong virus was taken in early September at the Nationl Communicable Disease Center in Atlanta and represents a 191.-700 magnification. Design by Mr. Ike Hussey, Higgins-McArthur Company, Atlanta.

JOURNAL OF THE MEDICAL ASSOCIATION Georgia

An adequate evaluation for this procedure requires not only an estimate of a woman's "mental health" but of her entire life circumstances.

Abortion for the Emotionally Disturbed?

SHELDON B. COHEN, M.D., *Atlanta*

In the fall of 1967 when the idea of this topic was broached, the law of Georgia was quite clear: It was a misdemeanor to perform an abortion except to "preserve the life of a woman."[11] The preparation of this paper presented a rather unique problem. As you remember, in early 1968 the Georgia Legislature had under consideration a change in the abortion statutes. Accordingly, there was no way of knowing at the time the ground rules that would be operative in May. Many of you recollect the impassioned pleas and, at times, frenzied rhetoric, that emerged in the legislative hearings. Cries of murder and the woman's rights were among those heard. These hearings, the changes in the bill before it was passed, and the Governor's allowing it to become law without his signature, all dispelled any lingering doubts we might have regarding the high emotional charge of this topic.

However, not having in hand the applicable statutes proved to be a blessing in disguise. It forced me to look at the whole problem, not from the standpoint of laws of one State at a particular time, but to consider the overall picture of what "therapeutic abortion for psychiatric reasons" is really all about. Of paramount importance is the notion of just what constitutes sound medical practice. The signs and symptoms of appendicitis are the same in Minnesota as they are in Georgia. Basic treatment of myocardial infarction in Los Angeles is no different from that in Augusta. Therefore, from a medical standpoint do not the same psychiatric indications for termination of pregnancy exist in all fifty States and the District of Columbia?

I should remind you that present law, i.e. the new law, which allows a physician to perform an abortion if his "best clinical judgment" indicates that "a continuation of the pregnancy would seriously and permanently injure (her) health"[12] succeeds a statute enacted in 1876. In that year a 20-year-old medical student named Sigmund Freud was engaged in a spare time research project attempting to discover the testis of eels. Although discovery of the male eel's gonads eluded him, in later years he made discoveries which markedly influence our understanding of man's mental functioning. Regrettably it took the law 92 years to incorporate this information!

Questions to Be Considered

There are several areas I will discuss, mentioning each and then coming back to them in some detail. First and foremost, a pregnancy, virtually any pregnancy, we all know to be a period fraught with much emotion. To consider properly the idea of an abortion we must begin at the beginning, i.e. why did this particular woman get pregnant at this particular time; what is the meaning of the pregnancy; and what is the true meaning of the request for abortion? We need, perforce, to concentrate on those women who react to a particular pregnancy in a manner

Presented before the General Practice and Psychiatry Joint Section Meeting, 114th Annual Session of the Medical Association of Georgia, Augusta, May 5, 1968.

psychologically destructive to themselves or others. We need to focus on the nature and severity of the aberrant behavior rather than the diagnostic label. If we do have a woman with a severe emotional disturbance, we must ask ourselves what sources of support there are from the environment, from family, friends, social agencies and the like.

As you have noticed from my title, I raised a question, "Abortion for the emotionally disturbed?" and did not specify the sex of the one who was disturbed. We must in all seriousness ask ourselves whether the major locus of the disturbance resides in the pregnant woman whom we are seeing or in the husband, boy friend, other family member, or society. We must ask ourselves about the realistic availability of therapy and the prognosis for the individual with and without therapy, and with and without abortion. I should like to give you the basic opinions held by psychiatrists as indications for abortions and similar data regarding the psychiatric sequelae of abortions. Finally, in the light of all of these factors I would like to consider present Georgia law and offer some ideas that may have utility in your practices.

Emotional Reactions to Pregnancy

We are all aware that pregnancy inevitably brings forth a marked increase in dependency needs on the part of the woman. Wenner[9] has noted "When she is abashed by her needs or feels hopeless about having them fulfilled, pregnancy is a crisis calling forth regression to infantile longing for omnipotent protection and care. This may be expressed in terms of general increase in anxiety, exacerbation of old patterns of dealing with anxiety (e.g. increased symptomatology), increased demandingness or rage or exaggerated fears for herself or the fetus." In a study[9] which she and her associates made of 57 pregnant women, it was found that the specific factor calling forth regression during pregnancy was lack of satisfaction of dependence in the marital relationship.

Mood swings occur in every pregnancy, especially during the first trimester when endocrinologic and metabolic adjustment may cause fatigue, sleepiness, headaches, vertigo, and even vomiting.[2] Of course, it is during just this time of "normal turmoil" that we are asked to give an opinion regarding advisability of therapeutic abortion. It is also important to realize that the "integrative task of pregnancy and motherhood—biologically, psychologically, and realistically—is much greater than a woman has ever faced before."[2]

Since pregnancy does produce such a profound alteration in living, virtually all women experience some fantasies of rejection and some desires to rid themselves of the products of conception, albeit generally in a fleeting and guilty manner. I think it is fair to say that if every woman with such thoughts were to be aborted, the future of the human race would be greatly in doubt. Contrariwise, we have all observed many women whose emotional state improved markedly during pregnancy and the amelioration of symptoms in certain schizophrenic women during pregnancy has led to investigation of the role of hormones in mental illness.

Reasons for Pregnancy

When confronted with a woman for whom the question of a therapeutic abortion is requested for emotional reasons, we must first ask ourselves two questions. Why did she get pregnant? What is the true meaning of the request for abortion? There are some women with impaired intelligence and/or a personality makeup which blithely ignores many aspects of reality, who become pregnant through a diminished awareness of the consequences of their behavior. For example, consider the case of Mary who at 17 was a chubby, unattractive bookworm, never kissed by a boy until she met a stranger while on a trip. This experience was pleasurable; she began sneaking out from home and found the only boys interested in her were those who wanted to have sex. It was wrong but enjoyable. Consciously she did not consider the possibility of becoming pregnant; when she did get pregnant, the boy told her "Don't look to me for help." She told her parents and "we got rid of the baby."

There is, of course, the fortunately not too common instance of the girl or woman who is forceably assaulted and impregnated. As the dramatic case of *Rex v. Bourne*[3, 4] illustrates, regardless of statutes on the law book, society usually accepts the termination of such a pregnancy. In April, 1938, a 14-year-old girl was raped and impregnated by four British soldiers. Dr. Aleck Bourne, an obstetrician, with the consent of parents and consultation with colleagues, performed an operation to terminate the pregnancy. He informed authorities of his action in order to be tried and have the law clarified. As a result English law was changed.

Ignorance and Rape

Actually ignorance and rape constitute a minority of women who present for abortion. The underlying motivation in the majority is a variety of unconscious and conscious emotional needs. The contents of the womb may have many emotional meanings. Freud saw pregnancy as an undoing of the castration complex, an attempt to retain the penis of the father

and therefore to be like him. The fetus may represent the admired beauty or the envied pregnancy of the patient's own mother. Frequently the fetus is the symbol of the loved self. Because of ambivalent feelings towards the self there may be many angry, hostile, homicidal impulses towards the fetus.

Very Sick Reactions to Pregnancy

Stress may call forth the reappearance of any previously existing but dormant symptoms, as well as produce new ones. The gamut of psychopathological reactions may occur, but we are particularly concerned with those which either openly or covertly are self-destructive. Deliberate starvation, forced eating, prolonged vomiting, flagrant disregard for proper rest, sleep, and attention to minor medical ailments may all lead to serious physical consequences as well as an exacerbation of emotional conflicts. Desperate, irrational attempts to obtain abortion may lead to permanent physical injury or death.

Threat of Suicide

Any suicidal threat should be taken with great seriousness because it is a measure of desperation and a call for attention and assistance. Although the suicide rate for pregnant women was formerly thought to be less than that for their non-pregnant peers, recent data fail to show any difference between the two groups.[10] Whenever the specter of suicide is raised, the woman and her situation must be considered on her own individual merits.

Consider the case of Mrs. "F," age 42, going on 43. Her present husband, a dozen years her junior, had consented to marriage only upon learning that she was pregnant. Three children from her previous marriage were seen as impedimentia to her narcissistic life and when lucky, were neglected rather than abused and scorned by her. She had twice made serious suicidal attempts, once ten years previously when pregnant with her youngest child, and again six months ago when she thought her boy friend, to whom she was now married, was deserting her. Following the last attempt there was a prolonged coma; she was referred to a psychiatrist, whom she saw a few times until her depression lifted somewhat, but she was unwilling to embark upon any extensive psychotherapy. When her husband was interviewed, he frankly acknowledged his intent to stay with her only until the pregnancy was terminated or the baby was delivered. Two psychiatrists recommended therapeutic abortion, the hospital abortion committee concurred, after which the patient refused to go to the hospital, instead seeking out an illegal abortionist.

Emotional Support From the Environment

It is a consistent observation that when a woman accepts her need for dependence and feels that help will be given to her, pregnancy is not a crisis.[9] The role of social factors on the experience of pregnancy is attested to by a recent study from the Hadassah Hospital in Jerusalem, which compared the reactions to first pregnancy of women from varying cultural backgrounds.[5] They found that when a woman came from a group where there was generally little communication or meaningful interpersonal relationship with her husband (including groups where the woman did not have anything to do with the choice of a husband) she "exploited her situation to make up for being undernourished in respect of concern and attention for herself as a person."

We must, therefore, ask ourselves what kind of help can this woman realistically get from her parents, her husband, boy friend or social agencies. The request for abortion may not stem from the patient but from a spouse who does not want a child. If we are to do a meaningful evaluation, then we must perforce include these relatives and others involved with the patient.

Miss "L," 22, was a lonely, frightened child-like creature who had continual conflicts with her parents. In order to please a casual date she consented to sexual relations and became pregnant. Her family and a community agency arranged for her to go to a distant city where she had the baby which was put up for adoption. Family eruptions continued when she returned home so that her psychiatrist and social agency concurred with her move to a different community. So concerned were they about her precarious condition that they alerted counterparts in the city to which she moved.

With their aid she obtained a job and managed to eke out an existence for a year until she again became pregnant. "He said he was sterile and I believed him. I'm stupid, that's why I always end up in trouble." Her emotional status worsened. She became bedraggled and depressed, obsessed with the pregnancy, and the treating psychiatrist recommended a therapeutic abortion. A second psychiatrist, not seeing a clear danger to life, did not concur. Miss "L" lost her job and the agency placed her in a succession of homes where she experienced humiliation, degradation, and finally panic. The only available resource was the State Hospital where she spent many months both before and after delivery of the baby.

Psychiatric Treatment

Does the patient desire treatment as a psychiatric patient or is her visit to us solely to obtain our

assistance in expelling the uterine contents? On a superficial level the vast majority of women who present themselves with an unwanted pregnancy consider themselves without significant emotional problems and desire neither counseling, intensive therapy, drugs, or hospitalization.

If we consider some kind of psychiatric intervention indicated, we may experience considerable difficulty in attempting to get the patient to acknowledge the existence of a problem and willingness to expend the necessary time, effort, and money. At times we have to face up to the unpleasant reality that available resources are inadequate in terms of clinic waiting lists, distance, expense, etc. For the unusual woman who initially comes in requesting an abortion, who acknowledges a need for help, and is willing to participate in therapy, the prognosis is as good as for her non-pregnant peers.

Prognosis

Based upon the preceding factors we need to consider the likely outcome under four sets of circumstances: (1) Continuation of pregnancy without abortion or psychiatric therapy; (2) abortion and concomitant psychiatric treatment; (3) continuation of the pregnancy with psychiatric treatment; (4) termination of pregnancy and no therapy.

Psychiatrists certainly should not play God, although this role is frequently pushed upon us and we sometimes find ourselves unwittingly accepting it. However, there is one other prognostic factor we must consider, i.e. what, with reasonable medical certainty, is the kind of mothering relationship the child will receive. Does the woman have capacity for warmth and/or has she shown ability to take reasonable care of another child? Or is she perhaps like one woman whom I saw who physically and mentally battered two previous children so it is doubtful that the most intensive psychiatric care can put them back together? Has a social agency taken responsibility for the mother's prenatal care and delivery and placement of the child? What we should aim for is a warm, intimate and continuous relationship with the mother or a permanent mother substitute.

Trend Toward Liberalization

If one examines the voluminous literature,[1, 3, 4, 6, 7, 8] confusion and contradiction is found, but certain trends emerge. First of all, on a topic so fraught with emotions one should expect that the feelings of psychiatrists, despite whatever reputation we may have for objectivity, will show through. The family structure in which the psychiatrist was reared, his value system, and his religion cannot help but influence an opinion where clear-cut objective criteria are so sadly lacking. It is a situation aptly called by Alan Guttmacher "the doctor's dilemma."[6] Certain trends, however, emerge.

Diagnosis, per se, is no absolute indication or contraindication since patients with schizophrenia, manic depressive psychosis, or a variety of neurotic disorders may improve or get worse with pregnancy. The general trend as reflected in surveys of physicians, articles by psychiatrists, and legislative action is towards "liberalization" so that any psychiatric condition which substantially presents a serious risk to the mother's emotional health may be considered an indication for therapeutic abortion on psychiatric grounds. It is generally recognized that there can be no blanket, absolute criteria; that as in all of medicine each individual patient must be considered on her own merits.

There is a substantial opinion, lay and professional, which considers disposition of the uterine contents primarily the prerogative of the afflicted woman, unless she is utterly bereft of her senses. Since the woman is rarely, if ever, prosecuted for inducing or securing an abortion, it is obvious that society tacitly endorses this view. Expressed differently, must a woman be "sick" in order to secure an abortion under medical auspices?

Psychiatric Sequelae of Abortion

Where once it was thought that abortion generally led to undesirable emotional consequences, a careful review of the literature by Simon[8] indicated marked discrepancies between various studies so that comparison is difficult. Thus, one author found no guilt and no post-abortion psychiatric illness, while at the other end of the scale, another author found 43 per cent of the patients with moderate to severe guilt and 12 per cent with post-abortion psychiatric illness. Other data by Simon[8] would indicate that therapeutic abortion may well be a stressful event for certain individuals but serious sequelae seem to be more related to pre-existing mental illness than any other factor.

Sterilization

If pregnancy and subsequent birth of a child would place undue psychic stress on a woman, would not another pregnancy lead to the same circumstances? Accordingly, possible concomitant sterilization is often considered.

As a rule psychiatrists view abortion and sterilization as two separate matters. In the psychiatrist's view the patient may not have the emotional resources to cope with a particular stressful situation but, due to alteration in life circumstances or emo-

tional growth, may successfully handle a later pregnancy. The obstetrician who is called upon to perform the surgery and who may see the previously aborted woman return again pregnant may justifiably feel used and desire to terminate what seems like an endless succession of pregnancies and requests for therapeutic abortion.

To my knowledge there is no adequate study of the frequency with which this sequence of events is repeated. Allowing for individuation there are two major categories which deserve differential treatment; the older, married woman with several children and the young girl, usually unmarried. Much of the stress in the older woman comes from handling the children she already has and therefore it would seem to be in the interest of her mental health permanently to prevent further pregnancy via sterilization.

Since the element of external support is so crucial in the ability to deal successfully with pregnancy, it is quite possible for the younger woman who becomes more stable via psychotherapy or other life circumstances to find a man who will support and nurture her. Furthermore, the loss of opportunity to become a mother with the associated devaluation of identity as a female may be an added emotional burden. Therefore, sterilization is generally contraindicated for the younger woman.

Recommendations

From a practical standpoint we recognize the request for therapeutic abortion as a matter of serious concern, which paradoxically demands a thorough investigation and a prompt decision. The woman asks that we rid her of this noxious growth yesterday. Technically the sooner the procedure is performed, the simpler is its execution, but we are also forced to take enough time to assure ourselves that reasonable psychiatric grounds exist for terminating pregnancy. In light of present Georgia law the following are conditions which generally should be considered as indications for therapeutic abortion:

(1) A patient with a history of *serious* psychopathology associated with a previous pregnancy: suicidal attempt, depression, loss of reality contact, psychosomatic symptoms.

(2) An individual with a chronic borderline adjustment where any significant psychological stress is likely to induce serious emotional consequences.

(3) An individual whose life circumstances are such that the pregnancy produces a loss of emotional support. For example, a single woman who has to move to another community, losing job, friends, and all ties. The family which becomes so openly hostile that they "psychologically abandon" their teen-age daughter. The husband who disappears upon learning his wife is pregnant.

Concept of Total Care

If we elect for an abortion, we must keep in mind the concept of "total care." Should we as physicians, whether we use couch or delivery table, allow abortion to be an end in itself, we have abrogated part of our professional responsibility. We should attempt to use all resources at our command to enable the patient and family to deal with the situation that precipitated the pregnancy so that the same untoward circumstances are not repeated.

The physician responsible for the physical care of the patient as part of his postoperative care should make certain the patient is thoroughly acquainted with effective contraceptive methods. It is essential that the patient be convinced of *her* responsibility in preventing unwanted pregnancies.

In the case of teenagers, the mother must also share this responsibility. Let the mother know that you are neither condoning nor encouraging her daughter to have sexual relationships, but the fact of the previous pregnancy is good evidence the practice will probably continue and it is the better part of wisdom to be prepared.

Psychiatrist's Task

If the patient is amenable to psychiatric care, the psychiatrist has a number of tasks. First is dealing with the theme of the tremendous maladaptive and self-destructive aspects of the unwanted pregnancy. Elucidation of the unconscious purpose of the pregnancy is also vital. For example, I have seen a number of intelligent, sophisticated women adept in the use of birth-control devices who unconsciously played "ovarian roulette" using their pregnancies to control and manipulate the behavior of their male consorts. It is also highly desirable to involve the man so that he can discuss what unconscious role he played in the production of the pregnancy and what problems of his own he was attempting to solve.

Summary

Georgia now has a liberal abortion law that permits termination of a pregnancy that may lead to serious and permanent injury to the woman's health. From a psychiatric standpoint an adequate evaluation demands study not only of the woman's "mental health," but of her entire life circumstances.

Among factors to be considered are emotional support available from the environment and the woman's desire for psychiatric aid. I have listed possible general indications for abortion and also consideration of associated sterilization. Finally, I

have stressed that termination of a pregnancy may be but the beginning of treatment.

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PHYSICIANS SEE LITTLE NEED FOR NEW DRUG COMPENDIUM

A nationwide survey of physicians reveals that 64 per cent feel current sources of prescribing information on drugs are adequate for their needs. The results of the survey, sponsored by the Pharmaceutical Manufacturers Association, were released recently by Albert Westefeld, Ph.D., vice president of Opinion Research Corporation which conducted the survey. A sample of 505 physicians chosen by strict sampling methods were personally interviewed in their offices in March and April.

Data from the study reveal that 21 per cent of the doctors feel it would be desirable to revise or expand existing sources of prescribing information, and only 15 per cent feel that an entirely new compendium of prescribing information is needed. "If a new or revised compendium of prescribing information were to be prepared, the majority of physicians would like to see the work in the hands of a consortium of nongovernmental scientific and medical organizations," Dr. Westefeld said.

Most Popular Source

According to the ORC data, *Physicians' Desk Reference* is the most frequently used source of prescribing information on drugs at the present time. When asked, "What are the principal sources you use for prescribing information?," 61 per cent of the physicians named *Physicians' Desk Reference*. The second most cited source was the physician's own experience and personal knowledge; 37 per cent gave this answer. Journals and medical periodicals were named by 27 per cent of the physicians, and detail men by 19 per cent. When shown a list of specific compendia and drug reference books, virtually all physicians say they use *Physicians' Desk Reference* to some degree.

When asked what kind of prescribing information they seek most often, doctors mention contraindications, dosage, and indications most frequently, Dr. Westefeld said.

Considerable attention was given in the study to what physicians would like in a compendium, if a new or revised one were to be prepared. Dr. Westefeld reported that 75 per cent of all physicians feel that a compendium covering the 600 most frequently prescribed drugs would be adequate for their needs.

Of the 21 per cent of physicians who feel it would be desirable to revise or expand existing sources of prescribing information, two thirds (14 per cent) name the presently available *Physicians' Desk Reference* as the best one to revise.

When given a choice of alternatives, Dr. Westefeld said, doctors indicate that they would like monographs in compendia to be listed both by brand and by generic name of the drugs included. However, in present usage, doctors are far more likely to look up a drug in a compendium by its brand name than by its generic name.

"The survey data suggest," Dr. Westefeld indicated, "that many physicians who cite a need for a new or revised compendium do not feel strongly on the subject." He gave the following reasons for his conclusion: Physicians who see a need for a new or revised compendium describe its characteristics in much the same way as physicians who say current sources of prescribing information are adequate. And those who see need for a new or revised compendium are little more likely to be willing to pay for such a publication than those who see no such need.

Strict Sampling Procedures

Dr. Westefeld explained the strict sampling procedures that were followed in conducting the study. "The Opinion Research Corporation national probability sample provided the geographic framework or starting point. The names of eligible physicians then were selected for the sample in proportion to the total number of eligible physicians in each location."

"The questionnaire was carefully pretested to insure that the questions were clear, unambiguous, and neutrally worded," Dr. Westefeld explained. "To eliminate any bias due to the sequence of the questions or the items physicians rated, several versions of the questionnaire were printed. The only change in these questionnaires was the order in which the questions or items were presented."

The 505 physicians who were interviewed were all under 65 years of age, in private practice, and engaged in nonhospital-based patient care.

Remarks before the MAG House of Delegates, May 6, 1968

The Student and Medical Education

CHRISTIAN N. RAMSEY, JR.* *Atlanta*

MR. SPEAKER, President Mauldin, Dr. Andrews and Members of the House. You have extended the privilege of this floor to a representative of the Student American Medical Association. No one —certainly not I—could arise to address this body without feeling profoundly a sense of history and tradition. Before me are massed the professional descendents of that small body of forward-looking physicians who, 119 years ago, formed the Medical Association of Georgia. We of SAMA, who are years your junior as an organization, can only hope that in the future we will be able to look back on a history as rich and productive as yours has been.

Dedicated to Knowledge

Our aims and aspirations are the parallel of your own. We, like you, are firmly dedicated to the nurture of that body of expertise and knowledge which forms the core of our profession. We, like you, are devoted to public service. We, like you, want to protect, defend, or change those standards which have made the very best health care in the world available to the people of the United States.

I would like to discuss with you today the role in which today's medical student finds himself and to communicate to you the mechanisms by which he is attempting to meet the challenges thrust at his feet.

Gentlemen, the medical student of today is in general better educated, better informed on the issues of the day, more concerned about the future of medical practice in this country, and more inclined to do something about it than you were when you were in medical school. The debates within our organization at all levels reflect the concern and interest of today's student with the future of medical practice. I can speak from personal observation when I assure you that they are bringing to these discussions much background information and well reasoned points of view.

I would categorize the concern of the present student of medicine into two broad areas: that of academic curriculum and that of defining the precise goals of the profession and the diverse ways and means with which to accomplish them.

Concern for Curriculum

In the area of academic curricula, students are making suggestions to planning committees and doing all within their power to recommend honestly changes which will enlighten and aid their descendents. In many schools, students are voting members of the curriculum committees. SAMA has been active in encouraging free liaison with the American Association of Medical Colleges, the AMA Council on Medical Education and other agencies devoted to developing solutions to the problems which exist in medical education today.

Student Feedback

We feel very strongly that student feedback deserves a high priority in efforts to determine the shape and direction of the education of the physician. In the past, medical faculties have demonstrated a studied and polished way of ignoring the talents and particular experiences of students as though they didn't matter.

To draw a simple analogy, none of you here today would attempt to treat hypertension or tachycardia without keeping constant vigil over the blood pressure or heart rate responses in your patient. We all know that a valuable part of any therapeutic ra-

* *Mr. Ramsey is a student at Emory University School of Medicine and vice-president of the Student American Medical Association.*

tionale and subsequent healing or curative process is the response the patient gives us to the regimen.

Similarly, students are in the unique position of being able to provide useful responses to the doses of education they receive—provided that organized and representative criticisms and recommendations are made to the proper officials.

Goals of the Profession

In order to determine the goals of the profession, students are evaluating the past experiences of American medicine in this area in terms of their own aspirations, desires, and emotions. Something happens to many students during the years in medical school. The attitude toward patients may shift from one of interest in them as human beings, with feelings like their own, to a cold roast attitude in which all that is important is the hard science of diagnosis and treatment. The human interest gets ground out. Such complaints as headaches with no organic lesions become "imaginary," not real. There is nothing imaginary about a headache. To the patient it is real. The patient is only asking for help —he is not fibbing or trying to mislead the doctor.

A number of factors which lead to these changes can be suggested:

First—The need of the student to develop a protective carapace so that he can tolerate the unpleasant experiences of the clinic. Each student must learn to handle the emotional disturbance caused by his patient's sufferings without allowing it to overwhelm him.

Second—In developing his attitudes towards patients the student will pattern himself to a considerable extent on the faculty and other senior doctors with whom he is associated. If they have not developed a mature attitude the student will reinforce his tough attitude.

Third—With the necessary expansion in schools to full time clinical faculty, the student sees medicine from a particular economic and social orientation which may not reflect the realities of private practice.

Early Contact With Patients

In order to meet these situations students are presently taking many steps. Outstanding examples are to be found in new student organized programs which provide the opportunity for patient contact early in the first year of medical school. These programs, developed in various sectors of the inner city, encourage the student to emphasize, during this contact, the behavioral, social and economic aspects of the patient's problem as well as the medical and physical considerations. By taking advantage of opportunities to learn about the methods of delivering medical care, in which context the relationship between physician and his patient may be explored fruitfully, the student is coming to understand the influences that affect his ability to function as a physician.

Joint Effort

Your responsibility, as senior members of the profession, lies in your obligation to encourage and nurture the commitment made by the student. He will call on you increasingly for advice and guidance. You must be prepared to defend or change your ideas in the light of the enthusiasm which is the hallmark of the medical student today. With your help and indulgence we, together, can shape and produce a system of unexcelled medical care for all people.

We, as students, realize that you have a great influence over our futures and those of our descendents. We stand committed to our ideals and are ready to demonstrate our abilities. I am confident that we, together, will succeed beyond all hopes. Consider the student to be what in truth he is—your junior partner in the unending effort to maintain and improve the standard of health care available to us all.

With our feet firmly rooted in the traditions of our profession—yet with metaphorical eyes on the stars—may each of us be able to say in the end "We have fought the good fight."

PLAN TO ATTEND

115th ANNUAL SESSION–MEDICAL ASSOCIATION OF GEORGIA

May 4-7, 1969

Savannah Inn and Country Club—Savannah, Georgia

The experimental studies outlined here showed greater security from leakage with the inverting anastomosis.

Intestinal Anastomoses: A Reappraisal of the Controversy

PANO A. LAMIS, M.D.,* JAMES T. RICHARDS, M.D.,†
WADDY W. CHAPMAN, JR., M.D.,‡ *and* WILLIAM M. RAMBO, M.D.§

THIS EXPERIMENTAL STUDY was undertaken in response to recent assertions that the everting mucosa to mucosa intestinal anastomosis has advantages over the inverting technique of serosal contact popularized by Lembert.[4] The everting anastomosis offers the appeal of technical ease and minimal bowel lumen stenosis, but the potential for leakage remains a major consideration. The application of the everting anastomosis has entered clinical use.[1] These revised concepts in intestinal surgery stimulated us to compare these two methods in our laboratories.

Materials and Methods

Thirty healthy mongrel dogs weighing from 8.2 to 19.1 kg. were selected at random. Principles of laboratory animal care as promulgated by the National Society for Medical Research were observed. The dogs were placed under light thiopental sodium anesthesia (25 mg./kg.) and midline abdominal incisions were made. Using moist sponges and gentle manipulation, sites approximately 25 cm. distal to the ligament of Treitz were selected for the jejunal anastomoses and approximately 25 cm. proximal to the ileocecal valve were selected for the ileal anastomoses.

In half of the animals everting anastomoses were placed in the jejunum and inverting suture lines in the ileum. In the remainder of the animals, the sites of the techniques were reversed. Both anastomoses were performed with single layers of interrupted 4-0 black silk sutures placed approximately 2-3 mm. apart. The everting anastomosis was sutured through the entire bowel wall thickness allowing mucosal to mucosal approximation. The inverting suture line was a seromuscular layer allowing serosal contact. After completion of the anastomo-

FIGURE 1

Inverted suture line. The arrow marked "A" points to the secure anastomotic site at 300 mm. of Hg. intraluminal pressure. The unmarked arrow shows serosal tears at this pressure.

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ses, the intestines were placed back into the abdominal cavity with no attempt being made to position the intestines or the omentum. The abdominal incisions were closed in layers without drainage.

Postoperatively, the animals were offered a standard kennel diet and water ad lib. Autopsies were performed on the dogs at the end of one week when the animals were sacrificed. Gross examination at the anastomotic site showed the degree of associated adhesions or abscesses. The anastomotic segments were removed for a length of 15 cm. proximal and distal to the suture line. The security of the suture line was then tested by increasing the intraluminal pressure at gradual increments until visual leakage occurred. Methylene blue stained water was introduced into the bowel lumen of the closed segment under increasing pressure. A blood pressure manometer attached to an inflatable bag which surrounded a collapsible plastic container of dye solution was used. As soon as the methylene blue stained leakage occurred, the values were recorded.

Sections were taken from the suture lines of randomly selected dogs and submitted for microscopic study. A measured segment of bowel inclusive of the anastomosis was weighed before and after desiccation and the water content of the suture line estimated. Measurements were taken of the intraluminal circumference at the suture line and compared to the circumference of the adjacent bowel.

TABLE I

INTESTINAL ANASTOMOSES INTRALUMINAL PRESSURE OF LEAKAGE

	Everting mm. of Hg	Inverting mm. of Hg
Dog No. 1	0	250
Dog No. 2	0	150
Dog No. 3	25	300
Dog No. 4	50	100
Dog No. 5	0	300
Dog No. 6	0	300
Dog No. 7	25	125
Dog No. 8	0	25
Dog No. 9	50	300
Dog No. 10	0	100
Dog No. 11	0	25
Dog No. 12	0	300
Dog No. 13	0	200
Dog No. 14	25	0
Dog No. 15	25	300
Dog No. 16	25	300
Dog No. 17	300	300
Dog No. 18	0	200
Dog No. 19	0	150
Dog No. 20	300	300
Dog No. 21	75	300
Dog No. 22	75	200
Dog No. 23	25	200
Dog No. 24	25	125
Dog No. 25	25	300
Dog No. 26	200	300
Dog No. 27	300	150
Dog No. 28	0	25
Dog No. 29	25	300
Dog No. 30	25	300
Mean Pressure	53.3	207.5

FIGURE 2

Everted suture line. The arrow points to the leaking suture line at minimal intraluminal pressure.

Results

Gross examination showed leaks or abscesses at 14 of the 30 everting anastomoses and at one of the 30 inverting anastomoses. There were many more adhesions associated with the everting suture lines. The mean pressure of leakage in the everting group was 53.3 mm. of Hg. and in the inverting group was 207.5 mm. of Hg. ($p < 0.01$). In the majority of the inverting intestinal segments, serosal tears were noted prior to or at the time of leakage at the suture line (Fig. 1). In three of the inverting anastomoses, leakage was noted at 25 mm. of Hg. but in 14 segments intraluminal pressures of 300 mm. of Hg. were tolerated without leakage (Table I).

In 12 of the everting anastomoses, the obvious disruption of the suture line precluded any intraluminal monitor measurement (Fig. 2). In ten of the everting suture lines, a pressure of 25 mm. of Hg. produced leakage at the suture line, and, in only three was an intraluminal pressure of 300 mm. of Hg. tolerated. The everting anastomoses decreased the intraluminal circumference by 6.5 per cent and the inverting anastomoses decreased the intraluminal circumference by 22.6 per cent ($p < 0.01$) (Table II). The water content of measured segments inclusive of the suture line was

determined. The everting segments showed significantly less water.

Microscopic Tissue Sections

Microscopic tissue sections were made in randomly selected dogs. In the inverting anastomoses, there was found to be almost complete re-epithelialization of the mucosa, and the separated ends of the muscularis mucosa and the muscularis of the bowel wall were closely approximated, being separated only by narrow zones of organizing granulation tissue. The defects were almost completely bridged by bands of young collagen. The collagenization was best seen in the Verhoeff-VanGieson and Masson's stains (Fig. 3).

On the other hand, in the everting anastomoses there were rather large tongues of everted, viable mucosa separating the two edges of the muscular wall and the muscularis mucosa. The defects were closed only by rather thin layers of inflamed granulation tissue, which were present well outside the muscular wall in the subserosal connective tissue. These layers of granulation tissue contained small amounts of collagen, but they were rather discontinuous, and the well formed bands of more mature collagen, as seen in the inverting anastomoses, were not present (Fig. 4).

Discussion

There are conflicting reports regarding the applicability of the everting anastomoses with its relative effectiveness as compared to the standard inverting technique. Getzen et al.,[2] in their experimental study, found the tensile strength of the inverting anastomoses to be about two-thirds that of the everting anastomoses up to 21 days. Thereafter, they found the strength of both anastomotic sites to be equal.

TABLE II

DECREASE IN INTRALUMINAL CIRCUMFERENCE AS COMPARED TO THE ADJACENT BOWEL

	Per Cent
Everting Group	6.5
Inverting Group	22.6

They also found evidence of significant obstruction with the inverting anastomosis which was not a factor in the everting method. The anastomotic edema of the everting anastomosis was significantly less than in the inverting type. Microscopically they found both the inverted and everted anastomoses to be identical in metachromase, reticulum and collagen formation. Getzen[1] reported on the clinical

FIGURE 3

Inverted suture line. Complete re-epithelialization of the mucosa and closely approximated muscularis mucosa and muscularis. Masson's, ×40.

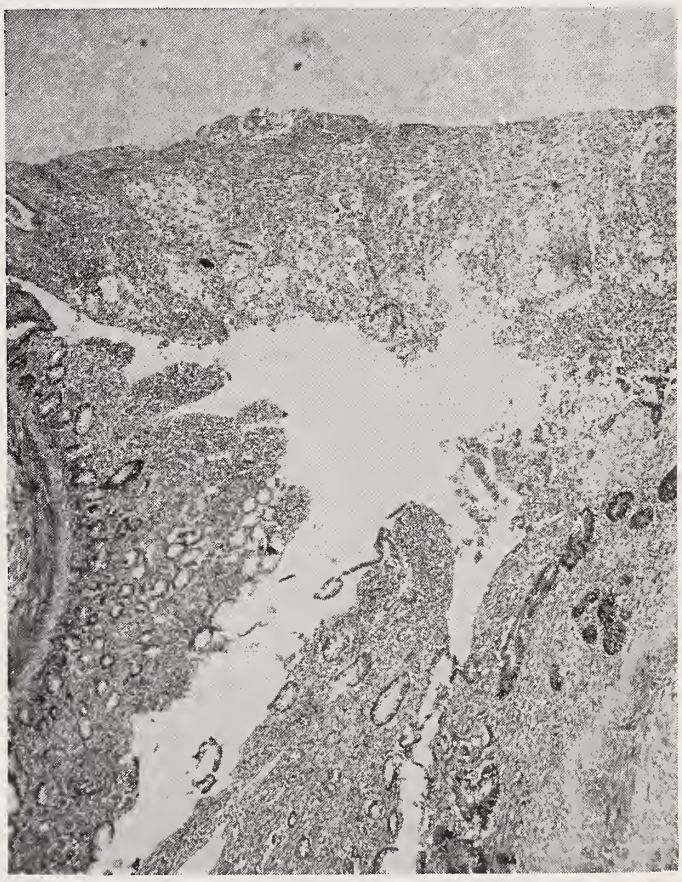

FIGURE 4

Everted suture line. A tongue of everted mucosa separates the two edges of the muscular wall and muscularis mucosa. Masson's, ×40.

application of the everted anastomosis and found no increase in morbidity attributable to this technique. Postoperatively, the patients with the everted anastomoses did better in return of intestinal function than the corresponding patients with inverted anastomoses.

Hamilton[3] compared experimentally various types of anastomoses and found that the everting method was technically simple and free of a stenotic cuff. However, he found very low leak pressures with air inflation and concluded hesitation in its use for any critical anastomosis. Mellish,[6] in a comparative study of small bowel anastomoses in rats, tested the healing strength by hydrostatic methods and found no significant difference between the two types of anastomoses. He did find, however, that the everting anastomoses significantly increased the chances for severe adhesions. In a study in dogs, Loeb[5] found that the everted anastomosis was weak and did not recommend its use.

Significant Variance

Our study showed many more adhesions at the everting suture line and more leaks and abscesses. The healing strength at the seventh postoperative day was different in the two methods of closure. There was a four fold greater tolerance to increasing intraluminal pressure in the inverting group. The level of intraluminal pressure that would be critical in these experiments and in clinical application cannot be stated with certainty; however, the marked variance in the two groups of anastomoses is interpreted as significant.

Greater Security from Leakage

This study also found more suture line edema and stenosis with the inverting method. It was easier, technically, to perform an everting bowel closure and it requires less operating time. These advantages of the everting anastomosis are definite factors favoring its use; however, the findings of greater security from leakage with the inverting suture line supersedes all other factors and is the most important consideration to the surgeon. Until more detailed laboratory investigation can clearly support evidence for acceptance of the everting mucosal approximation over the inverting suture line, we cannot recommend its clinical use in intestinal tract surgery.

Summary

Thirty dogs underwent small bowel anastomoses utilizing the everting and inverting techniques. On the seventh postoperative day, the animals were sacrificed and autopsies were performed. Gross examination showed leaks or abscesses at 14 of the 30 everting anastomoses and at one of the 30 inverting anastomoses. The security of the suture line was tested by increasing the intraluminal pressure until leakage occurred. There was greater security from leakage with the inverting anastomosis. Microscopic sections showed increased healing at the inverted suture line. The everting anastomosis had less edema formation and less reduction of the bowel lumen, but, more important to the surgeon is the fact that there was greater security from leakage with the inverting technique. This study supports the continued preference for the inverting serosal anastomosis in intestinal surgery.

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FRAUDULENT BILLINGS PLAGUE PHYSICIANS

The following statement was received from the Security department of the Southern Bell Telephone and Telegraph Company in Atlanta:

"During the past several years our Company, as well as other Bell System Companies in the United States, has been plagued with complaints from our subscribers due to the receipt by them of billing statements and/or solicitations from various directory publishing companies. Many of these subscribers have actually paid these companies, believing they were paying the Telephone Company for Yellow Pages advertising.

"At the present time, all attorneys and physicians throughout Georgia are receiving such statements and we feel it would be appropriate . . . to apprise your membership of this practice in the legal and medical journals.

"We have previously advised the Better Business Bureaus and Chambers of Commerce, as these publishing companies in the past have sent such statements to all kinds of business organizations in Georgia as well as throughout the United States.

"Some prosecutions have been attained by the United States Postal Inspectors due to violation of the Fraud by Mail Statute, and the practice is also under investigation by the Federal Trade Commission as a Deceptive Fraud Practice."

The accurate estimation of myocardial function is crucial in the evaluation of surgical risk in these patients.

The Evaluation of Left Ventricular Myocardial Function in Patients Undergoing Cardiac Surgery*

JOSEPH W. LINHART, M.D.,† *Miami Beach, Florida*

In the evaluation of a patient with valvular or coronary artery disease, the history and physical findings may disclose that a significant functional impairment is present. It is not generally possible from the clinical examination to separate adequately that limitation due to mechanical factors (such as valvular disease) from that due to a concomitant abnormality of the myocardium. The rheumatic process itself, and/or changes secondary to a valvular lesion, may result in such significant changes in the myocardium that the status of the heart muscle becomes the most important factor relative to the patient's operative risk and subsequent morbidity. Myocardial function may also be adversely affected by coronary artery disease increasing the functional limitation in patients with valvular disease. This is of additional importance now that surgical measures for the relief of isolated arteriosclerotic heart disease are available.

Diagnostic Tests

In order to gain information regarding the myocardial status in a given patient, various physiologic and angiographic procedures are performed in exercise and cardiac catheterization laboratories. The present clinically applicable examinations include: (1) *Measurement of left ventricular end-diastolic pressure (LVEDP) and cardiac index (CI).*

Although a high LVEDP was once considered to indicate left ventricular failure, we now know that the LVEDP may be elevated due to a pressure load (aortic stenosis) or volume load (aortic or mitral regurgitation), and no evidence of left ventricular failure or poor left ventricular function may be present.

Similarly, a reduction in CI does not necessarily indicate poor myocardial function in patients with valvular disease. An elevated end-diastolic pressure in patients with coronary artery disease has more significance however, as our studies have invariably demonstrated a decrease in left ventricular function in these patients.

Since measurement of resting intracardiac pressure and cardiac index may provide incomplete data in some cases, the patient's response to: (2) *muscular exercise* can be determined.

The relationship between LVEDP, cardiac output, stroke work and volume, and oxygen consumption is determined at rest and during exercise, usually in the supine position on a bicycle type ergometer. Normally, the cardiac output will increase by more than 500 cc. per minute for each 100 cc. increase in minute oxygen consumption. Also, the LVEDP will fall or increase by no more than 2 to 3 mm.Hg. while the stroke work and stroke volume rise. A failing or abnormal left ventricle will have

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Prepared by the Georgia Heart Association.

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a significant rise in LVEDP (more than 3 mm.Hg.), associated with little increase in stroke work and a falling stroke volume.

Angiotensin Infusion

A common method used in our laboratory to stress the LV is through: (3) *angiotensin infusion.* In this test, angiotensin is infused, I.V., in doses of 2 to 4 micrograms per minute to produce increases in arterial pressure (afterload) in systolic increments of 25 to 30 mm.Hg. The normal LV responds to this stress by large increases in stroke work with only small increases in LVEDP. A poorly functioning LV increases its end-diastolic pressure (EDP) markedly, but the stroke work rises slightly or even decreases.

This test has proven to be especially valuable in patients with coronary artery disease where it may provide the only indication of decreased LV function.

Muscle function may also be evaluated, qualitatively by: (4) *angiography.*

The injection of contrast material into the LV is filmed on 16 or 35 mm. film and then evaluated in various ways for chamber size and shape, sequence, uniformity, and magnitude of contractions, and for associated abnormalities such as mitral valve insufficiency or ventricular aneurysm. Abnormalities in the contraction pattern indicate a disorder of left ventricular function. We have found an excellent correlation between LV function demonstrated in this manner and the angiotensin stress test when the LV cineangiogram denotes abnormal function. The LV cineangiogram may be entirely normal, however, and an abnormality of function may only be demonstrated by some form of LV stress testing.

It is also important to determine the angiographic integrity of the coronary arteries in the preoperative evaluation of a patient with valvular heart disease. Although a patient with severe coronary artery disease may have normal LV function, more often there is a functional impairment which affects the immediate surgical risk and subsequent long-term results. This is over and above the risk inherent in the valvular surgery itself.

Indirect Estimates Only

It must be mentioned that although these four routinely used methods are valuable for the determination of left ventricular function, they are only indirect estimates. It is more appropriate to relate the tension or force developed in a muscle to the extent and velocity of muscle shortening. This is only done experimentally, today, and necessitates numerous assumptions in patients. Eventually, however, it will be possible to extend these techniques to routine clinical practice.

High Risk Patients

Clinical experience has now shown that in otherwise comparable patients those with poor myocardial function have the highest operative risk, stormiest post-operative course, and the poorest post-operative function. Several factors may be important to explain post-operative morbidity to patients undergoing valvular replacement: (1) Significant leakage around the rim of the prosthetic valve; (2) other residual valve lesions; (3) prosthetic valve gradients; (4) coronary artery disease; (5) poor myocardial function.

It is necessary to determine, using the previously mentioned diagnostic tests, which of these factors is important since the first three, and occasionally the fourth, are open to direct surgical attack. Unfortunately, in our experience, most of the poor surgical results have been associated with significantly impaired myocardial function. The patients present with evidence of congestive heart failure and since the mechanical factor (valve lesion) has been relieved, it is easier to obtain evidence of the true state of the myocardium. In some however, severe coronary artery disease is contributing to this malfunction, especially in older patients following aortic valve replacement. When isolated myocardial dysfunction is found, only intensive medical therapy can be offered.

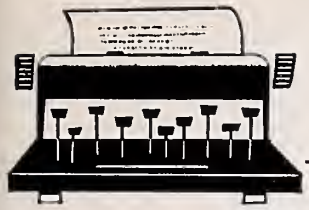
LAYMEN ARE INSTRUCTED IN EMERGENCY CARE

For two days, laymen were given the opportunity to be students at the Medical College of Georgia in Augusta. On September 5-6 a seminar, "Immediate Care of the Sick and Injured" was offered to policemen, firemen, ambulance attendants, nurses, teachers and others who are likely to find themselves in a position of being a rescue worker. Dr. Walter J. Brown, Jr., associate professor of medicine, was coordinator for the course.

This was the fourth consecutive year that the special instruction has been offered to laymen. Formerly, the course was held for first-year medical students. Then officials at the Medical College decided it would be a worthwhile program for persons who may be the first to reach the scene of an accident or catastrophe.

The enrollees heard talks and saw demonstrations on such topics as burns, poisons, convulsions, cardiac massage, resuscitation, heart attacks, shock, fractures, eye injuries and transporting the injured.

The Medical College presented the course in cooperation with the Office of Medical Education for National Defense, the Georgia Department of Public Health and the Medical Association of Georgia.



EDITORIALS

Committee Conclave

MANY "FIRST'S" WERE ESTABLISHED for MAG at the First Annual Committee Conclave, September 7-8, 1968, at the Marriott Motor Hotel, Atlanta. First of all, there were 22 Committee Chairmen in the same room, at the same time, to discuss their mutual problems, and no one can remember a similar gathering. The Conclave closing, with the Committee Chairmen reporting their plans and objectives to the Executive Committee of Council, was a new event in MAG's growing list of new activities.

More than 100 members of MAG were involved in the Conclave during the two-day sessions, with many members having the opportunity to visit multiple committee meetings of interest to them. A total of 26 committee meetings were ultimately convened, including a gathering of County Society Executive Secretaries, and a caucus of MAG's delegation to the American Medical Association.

As the Chairmen's critique forms are completed by each Chairman and returned to the Headquarters office, the value of the Conclave becomes more apparent. Plans are now being made for the Second Annual Committee Conclave to be held in July, 1969.

Conference on Emergency Medical Services Scheduled for December 1-4

A CONFERENCE ON EMERGENCY MEDICAL SERVICES is scheduled for December 1-4 at the University of Georgia Extension Division in Athens.

The Conference is the first of its kind to be held in Georgia and is designed to bring to Community leaders throughout the State the latest information on the topic of emergency medical services and traffic safety. Physicians, law enforcement officers, legislators and numerous other disciplines will be represented.

Appearing on the program on Monday, December 2 will be Dr. John Venable, State Health Officer; Dale Clark, WAGA-TV; Robert Oswald, American Red Cross; Roswell Brown, American College of Surgeons; Irving Hendryson, AMA Board of Trustees; Nils Lofgren, Insurance Institute of Highway Safety, and Alan Nahume and Arnold Seigel of UCLA.

Tuesday's program will begin with Honorable Bill Williams, Gainesville, followed by Douglas Kendricks, Grady Memorial Hospital; Henry Malone, Georgia State College; Governor Maddox and eight workshops.

Wednesday, the final day, will include Robert Wells, American Academy of Orthopedic Surgeons, Governor Pyle of the National Safety Council, and Ben Jordan, Georgia Safety Coordinator.

Attendance is limited to a maximum of 200. Physician attendance will be limited to 40. Travel, room and board and other allowable expenses will be defrayed by a grant for those who participate. Those desiring to attend should address their request to MAG Headquarters, 938 Peachtree Street N.E., Atlanta 30309.

The Threat of "Hong Kong Influenza"

MORE THAN 11 YEARS AGO, in the spring of 1957, an outbreak of influenza was reported from Hong Kong. The viruses isolated at the time were found to be antigenically distinct from all previously known influenza virus strains, and were classified as A2 (or "Asian") strains. It quickly became apparent that persons with a history of previous type A influenza infections were susceptible to the new strain. In addition, vaccines available at the time did not offer significant protection against A2 influenza.

The worldwide pandemic of A2 influenza that occurred during the fall and winter of 1957-1958 is remembered vividly by both practitioners and public health officials. In the United States, 86,000 deaths were attributed to influenza, and the disruptive effect on the millions of persons with clinical influenza was inestimable. Georgia's experience was typical of many areas of the country. A total of 122 of the 159 counties in the State reported outbreaks of influenza. Industrial absenteeism in Atlanta was notably high during the months of November and December 1957. Physicians were beseiged by large numbers of acutely ill individuals, to whom they could offer no more than symptomatic relief.

New Outbreak in Hong Kong

In July 1968, an outbreak of more than 300,000 cases of A2 influenza was reported from Hong Kong, the largest epidemic in that area since 1957. Approximately 30 per cent of the staff of the American Consulate in Hong Kong experienced influenza-like illness during the epidemic. The viruses isolated during the epidemic in Hong Kong show a marked antigenic change from earlier strains of A2 influenza virus—a situation similar to the one 11 years ago. Since these viruses do cross react to some extent with previous A2 strains, the current strain is still technically considered an A2.

In mid-August, outbreaks of influenza began in Singapore, Taiwan, and the Philippines. The 1968 Philippine epidemic is reportedly the worst there since 1957. The "new" Hong Kong strain of virus has been isolated from all of these areas. Military personnel returning from the Philippine Islands introduced the infection into Hawaii. Rates of illness among American military populations have ranged from 20 to 50 per cent.

Cases Reported in Atlanta

On September 2, 1968, two cases of influenza-like illness were reported in Atlanta. The first patient, a 42-year-old Marine Major became ill with fever, malaise, cough, and myalgia four days after returning from the Far East. Two days later, his wife (who had not left the United States) also became ill. A2 influenza virus was isolated from both patients. These agents have been shown to be like the Hong Kong strains. By the end of September, however, no other cases had been reported from the Atlanta area.

Cases of influenza documented as due to the Hong Kong strain have been reported from a number of States. With the continuous air and sea traffic from the Far East, it is not surprising that introductions of influenza into the United States continue to occur. No epidemics have been reported in the civilian population of the United States through the first week in October.

What to Expect

What can we expect during the coming year? Most influenza experts believe that because of the recent antigenic change in the virus, A2 influenza will occur

extensively in the United States during the 1968-69 season. (Even the prestigous journal *Time* reports "New Flu Due.") The high incidence rate reported for various American population groups overseas increases the probability.

Vaccines now available do not contain the "new" Hong Kong strain. Experience (particularly in 1957) has shown that protection through vaccination depends upon the antigenic similarity of the vaccine strain and the virus prevalent in the community. Available vaccines can be expected to provide only limited protection, at best, against the new Hong Kong strain. Better protection will require a new vaccine formulation. The new strain has already been supplied to the pharmaceutical companies that manufacture influenza vaccine; no effort is being spared to develop vaccines with the new strain as rapidly as possible. Such preparations should be available, though in limited quantity, early in 1969.

In the interim, the Public Health Service is recommending that currently available bivalent and polyvalent influenza vaccines be given only to persons at highest risk of mortality or severe complications as a result of influenza. When the new vaccine becomes available, these same groups should be vaccinated—or revaccinated—with it.

Priority for High Risk Groups

High risks groups include persons who suffer from chronic debilitating diseases (particularly cardiovascular and pulmonary conditions) and all persons in the older age group. Clearly, these patients should be given high priority to receive vaccine.

While the inactivated influenza virus vaccines are the best known preventives of flu, they are among the least satisfactory immunizing agents in general use today. They have been marginally effective, frequently offering only rather brief periods of protection. They also cause local and systemic reaction with relatively high frequency. Because of these limitations, the recent Public Health Service Advisory Committee on Immunization Practices is encouraging only selective administration of vaccine to older and chronically ill individuals. Antiviral agents have been suggested as an alternative until better vaccines can be developed; however, their ability to prevent influenza under epidemic conditions has not been established.

Though it appears likely that this will be a big year for influenza, it should be pointed out that influenza predictions (like weather forecasts) have been wrong on occasion. There is no guarantee that there will be widespread epidemics, but the best available evidence suggests trouble and we must be prepared to do as much as possible for those at greatest risk.

John J. Witte, M.D.,
Chief, State Services Section, Epidemiology Program,
Asst. Chief, Immunization Program,
National Communicable Disease Center, Atlanta.

NATIONAL HEALTH SCIENCE CENTER TASK GROUP MEETS

The National Health Science Center Task Group of the Georgia Science and Technology Commission met on August 22 to discuss plans for the year.

It was the consensus of the group that the Commission's responsibility as an advisory body to the Governor and Legislature was to recommend programs which will keep young graduates in Georgia as well as attract new industry and hold onto the present industry.

Examples of the methods and areas of operation of the Commission were: (1) The Oceanography program; (2) The Georgia Health Careers Council; and (3) The Science Honors Night.

It was the opinion of the Task Group that it should concentrate its efforts in three major areas: (1) Health Systems Design; (2) Bio-Instrumentation; and (3) Environmental Perturbations of the Biosphere.

TO OUR LADIES

MOST OF OUR DOCTORS are inclined to take our Women's Auxiliary too much for granted. As has been stated by Dr. W. C. Mitchell, Chairman of your Auxiliary Advisory Committee, the members of the MAG should get to know their Auxiliaries better. This means individual members, local county and district societies and our wonderful WAMAG.

We are not nearly so knowledgeable as we should be concerning their goals, their aspirations and the amount of dedicated effort they exert mainly for us. They are a most important asset to our organization. Does the average doctor stop to think of the many ways they bolster our public relations, how much they help with our communications, and the things they do to improve our image?

Consider the very productive efforts they put forth in many things—AMA-ERF, Health Careers Student Loan Fund, International Health, Mental Health, Disaster Preparedness and Safety, Rural Health, Community Service—and actually on ad infinitum. Their annual themes are in themselves inspiration. Last year under Mrs. Manning's presidency they had "Unlimited Dimensions," and this year with Mrs. Phillips at the helm, it is "Auxiliary Horizons." They are constantly coming up with new ideas and it might well behoove us to borrow some as we go along.

If you have not paid attention to the Auxiliary publication "The WAMAG Pulse Line," it is my recommendation that you do so. If you are familiar with it you will be pleased with the new format.

In this month of Thanksgiving, let's give thanks for our ladies and their most helpful and excellent organization. They have the inspiration to action—the most important ingredient to continued success.

Charles R. Andrews Jr. M.D.

Charles R. Andrews, Jr.
President, Medical Association of Georgia

"WHO IS A MEDICAL EXPERT?"

JOHN L. MOORE, JR., ***Atlanta****

A RECENT QUESTION POSED by a medical staff member of a hospital caused this writer to look into the Georgia rulings on whether a hospital staff officer who is not yet licensed to practice medicine in Georgia may testify as a medical expert. Much to his surprise, this writer found Georgia cases have gone pretty far in allowing persons to testify as "experts."

Basic Provision

The basic statutory provision says that the opinions of experts, on any question of science, skill, trade, or like questions, shall always be admissible; and such opinions may be given on the facts as proved by other witnesses.

This definitely means that in some cases persons who are not licensed as medical doctors may testify on medical questions in court. As construed by most courts, it also means that any person who has a medical license may testify on any medical question, even though it is outside his field of specialization.

Precedents in Georgia

In a 1948 decision of the Court of Appeals of Georgia, an undertaker who embalmed the murder victim's horribly mutilated body was allowed to testify:

"In my opinion, based on 15 years of dealing with dead bodies, the vital organs were removed by a human being. I could not swear definitely that they were removed by a human being, but that is my belief; in other words I will say they were removed by a human being."

The Court held that a proper foundation was laid so that the undertaker, not otherwise qualified as a scientist, could testify as an expert on the subject raised.

In 1928, the Court of Appeals of Georgia held that a person who has practiced as an x-ray specialist for 15 years could give his opinion after taking an x-ray as to whether certain bones of the patient had been injured in an accident. This was true even though the witness was not a graduate of a medical school and was not licensed to practice medicine. The Court observed that the specialist had made a special study of the anatomy of the human body during his 15 years as a specialist.

In a 1905 decision of the Supreme Court of Georgia, at a time when osteopaths were not well known in Georgia, a practitioner of osteopathy was allowed to testify concerning the nature and probable duration of injuries sustained by the plaintiff in the case. The Supreme Court pointed out that the osteopath attended a school of osteopathy where he had taken a ten months course in physiology. It also said that the osteopath had read certain text books on physiology, anatomy,

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* *Prepared at the request of The Medical Association of Georgia. Mr. Moore is a member of the firm of Alston, Miller & Gaines, General Counsel to The Medical Association of Georgia.*

pathology, and the practice of medicine. Apparently, the particular osteopath had not been in practice very long and the court relied upon his book learning. In arriving at this decision, the Supreme Court of Georgia said the following:

"Had he been licensed under the laws of this State to practice medicine, it is clear that he would have been competent to testify as an expert witness, upon the fact being made to appear that he was a licensed physician. . . . Not being a licensed practitioner, it was necessary to lay the proper foundation showing him to be an expert as to the subjects on which he proposed to express his opinion. We think the necessary foundation was laid."

In certain other instances, the Georgia courts have not been willing to accept as experts those who are not medical doctors. This has been true where the plaintiffs themselves tried to testify that their own injuries were permanent and did not present any professional testimony to that effect. It has also been true in cases where plaintiffs try to prove that a physician was guilty of malpractice in treating them. In those cases, the Georgia courts have said that only physicians can testify to a proper standard of medical care.

Practical Experience Is a Qualification

However, as illustrated in this article, it appears that practical experience will, in some cases, qualify a person to testify on what might otherwise seem to require medical expertise. Several cases have admitted testimony of coroners who have had much experience with dead bodies. That seems reasonable.

It is also interesting to see the courts uniformly recognizing any holder of an M.D. degree and a medical license as a universal expert on science. The same judge who rules a recent medical school graduate competent to testify on very specialized questions of medicine may well himself seek out the most eminent specialist if he stands in personal need of care.

One practical reason may have compelled courts to take both positions. It is frequently difficult to obtain expert medical testimony, especially in small communities where specialists do not practice. If some relaxation of the rules were not made, it might well be that many meritorious cases would go untried.

Suite 1220,
C & S Bank Building.

EMORY OFFERS TRAINING IN SUICIDE PREVENTION

A regional center to train workers in suicide prevention is to be established at Emory University in Atlanta. Charles H. Edwards, M.D., director of the project, said the program will offer short-term training in suicide prevention for both professional and nonprofessional workers in the southeastern area of the United States.

He said the program will be a flexible one, to meet the differing needs of communities represented by the trainees. Among the opportunities for trainees will be training for emergency telephone operators, development of techniques for establishing suicide prevention and emergency mental health services, and clinical training for professional personnel.

Nonprofessional workers, including volunteers, can enroll in monthly two-day training sessions; professional workers will attend quarterly three-day seminars. Instruction will be offered by the Department of Psychiatry of Emory University in cooperation with the Fulton County Emergency Mental Health Service. The training is supported under a grant from the National Institute of Mental Health.

NEW PROFESSIONAL EDUCATION FILMS ON CANCER RELEASED BY THE AMERICAN CANCER SOCIETY

JOHN P. WILSON, M.D.*

In January, 1967, the National Medical and Scientific Committee of the American Cancer Society, on the recommendation of the Professional Education Committee, approved a resolution revitalizing the Society's entire professional film library. This is one of the largest undertakings of its kind ever made against a single disease. Since that time, 11 new professional films have been released. These are: "Oral Cancer," "Nursing Management of the Patient With Cancer," "Cancer in Children," "Diagnosis and Management of Cancer of the Colon and Rectum," "The Dentist and Cancer," "Tumors of the Major Salivary Glands," "Cancer of the Skin," "Early Diagnosis and Management of Breast Cancer," "Uterine Cancer: Diagnosis and Management," "Diagnosis and Treatment of Cancer of the Stomach," and "Diagnosis and Treatment of Cancer of the Prostate." All of these are narrated by outstanding specialists in their field, and are produced in 16 mm. color.

Definite Need Established

Before a film is produced, the need for it has been evaluated by the Society's National Sub-committee on Films and the Professional Education Committee, and its production approved by the National Medical and Scientific Committee and the Board of Directors. Each film is viewed and approved after it has been produced, but before it is released, agreement is reached that it is of the highest quality and is medically sound and acceptable throughout the country.

Exclusive of the cost of the print, $25,000 to $35,000 of the Society's contributed funds have been invested in the production of each film . . . money which benefits no one unless the film is seen.

Aimed at Non-Specialists

The target audiences of the Society's films are primarily medical students and practicing physicians who are not specialists in the diagnosis and treatment of cancer, but who in their practices have the opportunity for the detection and early management of the cancer patient. Emphasis is placed on prevention where possible, and on symptoms, physical findings and patient demonstration in order to help in early recognition and differential diagnosis.

The Society's films aim to demonstrate the significance of the cancer under discussion as related to other diseases and sites of cancer, and to show the importance and methods of early detection and diagnosis. The principles of treatment and management are covered in order to improve referral and initial medical pro-

* *Chairman, Professional Education Committee.*

cedures. Definitive treatment is not presented in sufficient depth to teach minute details, but in order to delineate and emphasize the principles involved. End results are covered.

Future Topics of Films

During the next year, release of films on solid tumors, bone tumors, ovarian cancer, moles and melanomas, lung cancer, thyroid cancer, radioactive isotopes, leukemias and lymphomas, and essentials of a cancer detection examination in the doctor's office can be anticipated.

The Society is particularly interested in use of these films by members of the Association of Hospital Directors of Medical Education, cancer committees of State and county medical societies, staffs of medical schools, county and State medical, dental and nursing societies. They are available at no cost to the physician or professional organization requesting them, and may be scheduled by contacting the local unit of the American Cancer Society, or the Georgia Division, American Cancer Society at 2025 Peachtree Rd., N.E., Atlanta, Georgia 30309.

GRMP INITIATES VISITING CONSULTANT PROGRAM

A Visiting Consultant Program for community hospitals is now being offered through cooperative arrangements between the Georgia Regional Medical Program, Emory University School of Medicine and the Medical College of Georgia.

Physicians, nurses and other allied health professionals will be available for teaching, problem solving and in-service education in area heart and cancer facilities as they are developed in hospitals throughout the State. Their services will include seeing problem patients, making ward rounds, participating in consecutive case conferences, in-service education and in the continuing education of both physicians and other allied health professionals. The area facilities are expected to become centers for continuing education in the subject areas of interest to the Georgia Regional Medical Program. Faculty members from both Emory and the Medical College, as well as specialists in private practice will be available for periodic visits to be scheduled on request by the area facility. All expenses will be underwritten by the Georgia Regional Medical Program through funds granted by the U.S.P.H.S.

Initiation of this project will achieve one of the primary purposes of the Georgia Regional Medical Program—"to afford to the medical profession and medical insitutions the opportunity of making available to their patients the latest advancements in the diagnosis and treatment of heart disease, cancer, stroke and related diseases."

Hospitals wishing to avail themselves of the services of this Visiting Consultant Program should contact:

(for Emory Faculty)
Bernard L. Hallman, M.D.
Associate Dean
Emory University School of Medicine
69 Butler Street, S.E.
Atlanta, Georgia 30303

(for Medical College Faculty)
Raymond P. Ahlquist, Ph.D.
Associate Dean
Medical College of Georgia
Augusta, Georgia 30902

(other sources)
J. Gordon Barrow, M.D.
Director
Georgia Regional Medical Program
938 Peachtree Street, N.E.
Atlanta, Georgia 30309

PEDIATRICIANS HOLD SCIENTIFIC MEETING

The 36th Annual Scientific meeting of the Georgia Pediatric Society was held in association with the Georgia Chapter, American Academy of Pediatrics on October 10, 1968, in Atlanta.

E. B. Singleton, M.D., Director of Radiology at St. Luke's and Texas Children's Hospitals in Houston, Texas opened the morning session. He spoke of the "Radiologic Evaluation of Respiratory Distress in the Newborn."

The second speaker was Andre J. Nahmias, M.D., who discussed "Three Years of TW_3ID Atlanta." Dr. Nahmias is Associate Professor, Department of Pediatrics, and Chief, Infectious Disease and Immunology Section at the Emory University School of Medicine.

The final speaker at the morning session was Jerome L. Schulman, M.D. of the Division of Child Psychiatry at The Children's Memorial Hospital in Chicago. Dr. Schulman spoke on interviewing techniques.

During the afternoon meeting, Dr. Schulman discussed the role of the pediatrician in adolescent adjustment problems. Dr. Nahmias spoke on "The Creepy Ways of Herpes Simplex Viruses," and Dr. Singleton closed the scientific session with a talk on the "Radiologic Evaluation of the Vomiting Infant."

REVASCULARIZATION OF THE MYOCARDIUM: THE VINEBERG PROCEDURE

WALTER J. LEWIS, III, M.D., *Augusta*

THE CHALLENGE OF IMPROVING THE BLOOD SUPPLY to the myocardium in a patient with ischemic heart disease has attracted the interest and the imagination of surgeons for many years. In 1946, Vineberg reported the implantation of the internal mammary artery into the left ventricle for myocardial revascularization. Thus, the blood supply flowing through the internal mammary artery flows directly into the myocardium and supplements the blood supplied through the narrowed coronary arteries.

Artery Remains Patent

Two questions must be answered about the Vineberg procedure: (1) Does the artery remain patent after its implantation into the myocardium, and (2) Does the implantation clinically improve the anginal syndrome? The advent of selective angiography demonstrated that the implanted internal mammary artery does remain patent in a number of patients, thus supplying blood to the myocardium.

Effler, Sones, and their associates performed internal mammary artery implantation on a selective group of 76 patients with angina pectoris. The operative mortality of 4 per cent was, in each instance, attributed to the underlying coronary artery disease. Of fifty patients re-studied nine to twelve months later by selective coronary and internal mammary arteriography, 33 had patent implants. Studies of 11 implants were inconclusive because the study was either inadequate or performed too soon after surgery, and six of the implants were occluded.

Since December of 1962, Dr. Vineberg has performed the internal mammary artery transplant in 130 patients, of which 100 have been followed from six months to three and one-half years. The results are presented in two groups.

Results of Artery Transplant

Group I of 77 patients had chest pain on exercise preoperatively. The operative mortality was 4 per cent. On the follow-up visit, Dr. Vineberg felt the overall improvement as defined by subjective improvement was 94 per cent. Only 35 per cent were able to work prior to the time of survey, but 72 per cent were able to work full time after recovery from surgery.

Group II consisted of 23 patients who were having chest pain at rest and, therefore, were more seriously ill. The operative death rate was 22 per cent. The rate of

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Prepared at the request of the Committee on Professional Education of the Georgia Heart Association.

subjective improvement in this group was considered to be 80 per cent. No patient was working full time preoperatively, and after surgery six were working regularly.

Gorland and Taylor selected forty patients with severe angina pectoris or a history of repeated myocardium infarction under the age of 45 for internal mammary artery transplant. The operative mortality was 5 per cent. Of 26 patients subjectively evaluated after surgery, 21 were subjectively improved. Morphologic patency was documented in 13 of 15 by selective cineangiography one year after the operation.

Change to Aerobic Metabolism

One important contribution to the objective determination of the effectiveness of the revascularization procedure is demonstrated by the change that occurred in the myocardial metabolism in patients with patent internal mammary artery transplants. In six of nine patients with patent implants as proved by cineangiography, determinations of myocardial lactate extraction before and after operation have demonstrated a change from anaerobic to aerobic metabolism. This is important objective information to add to the subjective feeling of improvement in patients who have undergone this procedure.

Personal experience with internal mammary artery implants was gained with 15 patients with disabling angina and angiographically proven coronary artery disease at the University of Virginia Hospital. Five of these 15 patients were re-evaluated symptomatically, by treadmill testing, and by angiography six to nine months after surgery was performed. All five patients were symptomatically improved as evidenced by an enhanced feeling of well-being and decreased use of nitroglycerin. Three of the 5 had returned to work. On the treadmill all had the ability to walk a longer period of time at increased speeds. By angiography all five patients had demonstrable flow of dye from the internal mammary artery into the myocardium.

Candidates for Vineberg Procedure

Who is a candidate for a Vineberg procedure? Most advocates of the procedure insist that it should be limited to patients who have incapacitating or recurring angina for six months in spite of adequate medical management. The presence of severe congestive heart failure or a large ventricular aneurysm is a relative contraindication. A previous myocardial infarction is not a contraindication as long as the patient is four months post-infarction.

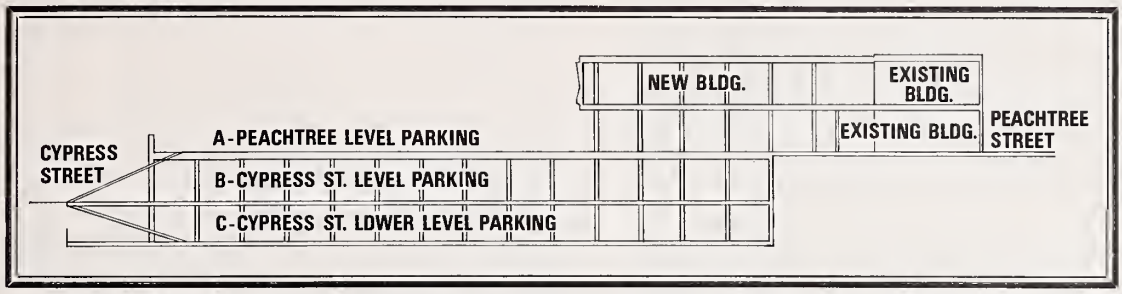
Coronary arteriography should be performed on every patient prior to consideration of a Vineberg procedure to evaluate the exact extent of disease in the coronary arteries and to identify areas of ischemia. With this information the surgeon can place the internal mammary artery accurately in the ischemic area of the myocardium.

It must be emphasized that symptomatic relief is not to be expected until 3-4 months after surgery because fine arterial radicals must have time to develop from the internal mammary artery into the myocardium. Hopefully, in the long range the patient with incapacitating angina may gain symptomatic relief from his pain and even return to gainful employment.

Medical College of Georgia

The heart is in accord with the pulse. The complexion of a person shows when the heart is in a splendid condition. The heart rules the kidneys.

—Huang Ti, "The Yellow Emperor's Classic of Internal Medicine"



This schematic drawing indicates the tri-level parking area and the 10,000 square foot addition to the existing building, both of which are included in the current stage of the expansion program. The drawing was provided by Thompson and Hancock, architects for the new building.

MAG'S NEW HEADQUARTERS

As instructed by the House of Delegates and the Council, your Committee on the Headquarters Expansion program is moving along.

We were instructed to build an addition of 10,000 square feet on the present building, but to plan in the beginning for an additional 50 or 60 thousand square feet, or more, with adequate parking facilities should the future need arise.

Accordingly, the above picture is a schematic drawing of the building.

At the present, we will build two sub-basement parking decks and one street level deck to extend under the addition of the building; the second floor will be the 10,000 square feet addition; the three parking decks will give us 145 parking spots, which will be adequate for the completed building. In the meantime, parking is critical in this particular area, and a nice income can be derived from renting the spaces.

We have secured a permanent loan for the building to be paid back over 19 years after the addition is completed.

Your Building Committee and the Executive Committee are quite optimistic. We firmly believe that the income from the addition to the building and the parking area will be adequate to retire the indebtedness of the project.

By the time this is published, we should have commenced work. Your Building Committee will keep in close touch with the Executive Committee and the Council, and with you through the Journal from time to time.

We hope it will be completed by the next Annual Session.

J. G. McDaniel, M.D., Chairman,
MAG Headquarters Expansion Committee.

THE SOCIAL SECURITY DISABILITY PROGRAM:

How Recent Amendments Will Affect the Physician and His Patients

Private practitioners came under social security in 1965. In addition to earning retirement and survivors protection, they may also have earned disability protection. Work credits could have been accumulated before 1965 through internships, residencies, military service and other covered employment. This article discusses the disability program, and how recent changes in the law affect the physician and his patients.

If you pay—or if you have ever paid—social security contributions on your earnings, you and your family may be covered by the social security disability program.

In the disability program, a worker under 65 may be eligible for monthly payments if he is disabled because of a severe physical or mental impairment which has lasted (or is expected to last) a year or longer. He must be unable to do not only his usual job, but any work in keeping with his age, education, and experience.

Increase in Benefits

The disability program was improved by legislation that became law early this year. As a result of an increase in benefits under the new social security amendments, monthly payments can amount to as much as $189.90 for a disabled worker and $395.60 for a family. In forthcoming years, maximum monthly benefits will be even higher.

To be insured for disability purposes, a person disabled when he is 31 or older needs to have worked under social security for at least 5 of the 10 years preceding the onset of disability. For younger workers, who may not have had the chance to work this long, the work requirement ranges down with age to as little as 1½ years of work credits.

Extended Coverage

Under the new amendments, an additional group of people—disabled widows (including certain surviving divorced wives) and disabled dependent widowers of insured workers—can become eligible for reduced benefits at 50 or older, even though they themselves never worked. The disability must occur before or within seven years after the spouse's death—or, in the case of a widow caring for a child entitled to benefits, within seven years after her benefits as a mother end. NOTE: Factors such as age, education and previous work experience are not considered in deciding whether a widow is disabled (as they may for a disabled worker).

Benefits begin with the seventh full month of disability. (A six-month waiting period is required by law.) Payments can last as long as the disability continues. At 65, payments to disabled workers are converted into retirement benefits without any change in amount.

Helping Your Patients

Many physicians routinely advise any patient who they think might qualify for disability benefits to consult his social security office. Such advice can be a great service to the patient. Since disabled patients are often having financial difficulties, your suggestion that they file may result in their getting urgently needed funds.

The people in any social security office can tell a claimant what the eligibility requirements are and can help him apply for benefits. If a person is unable to come to the office because he is homebound or hospitalized, a social security representative can arrange to visit him.

Up to the present the most frequent causes of disability have been arteriosclerotic and hypertensive heart disease, emphysema, schizophrenic disorders, pulmonary tuberculosis, rheumatoid arthritis and osteoarthritis. Currently in Georgia about 37,262 disabled persons—plus about 33,613 dependents—receive about $4,682,762.00 a month in benefits under the social security disability program.

Reporting Data

When a patient applies for disability benefits, he is expected to furnish reports from his treatment sources for use in evaluating his claim for disability benefits.

Disability decisions under the social security program are made by an evaluation team consisting of a physician and a lay disability evaluation specialist. The team works in an agency of the State in which the applicant lives—in Georgia, at the Office of Vocational Rehabilitation Services.

Typically, the evaluating physician is a private practitioner serving the agency on a part-time basis. He reviews the reports from physicians and hospitals and, in conjunction with the non-medical member of the team, decides whether the applicant's impairment is disabling under the law. The evaluating physician neither sees nor examines the patient. He depends entirely on the evidence reported by you and others who have examined or treated the applicant.

Experience has shown that the extent of a patient's disability can be determined largely on evidence from his own physician's records. By giving a detailed report of objective data in your files, you can help speed the decision on your patient's claim. On the other hand, long delays can result if the physician responsible for evaluating the evidence must write back to you or seek from other sources medical information about symptoms, signs and laboratory findings that you may already have in your files.

Furnish Complete Reports

To be most helpful, report the same information that you would send any colleague to give him a complete medical picture of the patient. This report should contain not only a diagnosis, but also a complete history, results of physical examination and relevant diagnostic tests.

You may wish to save time in preparing the report by enclosing photocopies of pertinent portions of the patient's chart, including laboratory reports, electrocardiograms, X-rays and the like. Originals are welcome and will be promptly returned if requested. Under the law, your patient—not the government—is responsible for providing the initial medical evidence in support of his claim.

Sometimes more medical evidence is needed for an

Prepared by the Social Security Administration.

evaluation than is available in the patient's chart. In this situation, the physician evaluating the claim may ask you to perform the needed tests and examinations at government expense, or he may find it necessary to refer the patient for an independent consultative examination, also at government expense. When the latter is done, the consultant's report can be sent to you if you wish.

"Childhood Disability"

In addition to covering disabled workers and disabled widows, the social security program has a provision for "childhood disability" benefits—a somewhat anomalous title since these benefits are paid after the person reaches 18. Ordinarily, children cannot get social security benefits as dependents after reaching 18 unless they are full-time students, and then only until they reach 22. But under the childhood disability provisions, a person continuously disabled since before reaching 18 can be eligible for benefits after he reaches 18.

Childhood disability benefits are payable when the beneficiary's parent covered under social security dies or becomes entitled to retirement or disability benefits. Benefits can continue as long as the "child" lives if he remains disabled. He need not himself have worked under social security.

Since 1957 the childhood disability program has awarded monthly benefits to nearly 300,000 persons too handicapped to be self-supporting. Over 65 per cent of beneficiaries under this program suffer from some form of mental deficiency. Other prevalent conditions of beneficiaries under the program include cerebral palsy, schizophrenic disorders and epilepsy.

Motivating Rehabilitation

In addition to paying cash benefits, one of the main goals of the disability program is to help restore as many applicants as possible to gainful work. At the time your patient's claim is being evaluated, he is also being considered for possible services by Vocational Rehabilitation. Such services—which include medical rehabilitation, counseling, teaching of new employment skills, training in the use of prostheses and job placement—are usually financed from State-Federal appropriations.

Additional resources are also provided through social security trust funds to pay the costs of rehabilitating certain disability beneficiaries. This should save social security money because in the long run the cost of rehabilitating beneficiaries is less than the expense of paying them benefits.

As the patient's physician, you are in a good position to reinforce his interest in returning to productive work, if this is feasible. Incorporated in the social security disability program are several incentives for rehabilitation that doctors often cite to help motivate patients.

For instance, a worker on the disability rolls who returns to work despite a severe impairment may continue to get monthly benefits for as long as a year while he tries to re-establish himself as self-supporting. If at the end of this period he shows himself able to work, benefits stop. Benefits continue, however, if his attempt is unsuccessful.

As a further incentive, former beneficiaries who have recovered or returned to work get special consideration should they again become disabled. If disability recurs within five years (seven years for widows), they need not go through another six-month waiting period before benefits resume.

Social Security Disability Provisions at a Glance

- Benefits go to disabled workers under 65 and their dependents.
- A disabled worker needs credit for a certain amount of work under social security. If he is disabled before age 31, he can now be eligible for benefits with credit for fewer years of work than before.
- Widows and dependent widowers who are 50 or older can receive reduced benefits based on disability, if the spouse was covered under social security.
- Persons handicapped continuously since before 18 may get benefits under the "childhood disability" provisions when a parent covered under social security dies or becomes entitled to retirement or disability benefits.
- Benefits are payable if the disability has lasted, or is expected to last, 12 months or longer or result in death.
- Benefits generally begin with the seventh full month of disability.
- Benefits for a worker are the same amount that retirement benefits would be if he were 65.
- All applicants are considered for vocational rehabilitation services.

GEORGIA HIGHWAY SLAUGHTER

Yearly Totals

1968 to date	1,263 Killed
1967	1,621 Killed
1966	1,605 Killed
1965	1,354 Killed
1964	1,314 Killed
1963	1,278 Killed
1962	1,106 Killed
1961	1,017 Killed

Through September, 1968
1263 KILLED

Same Period 1967
1204 KILLED

September, 1968
141 KILLED

Economic Loss

1968 to date	$239,970,000
1967	291,780,000
1966	288,900,000
1965	243,720,000
1964	236,520,000
1963	230,040,000
1962	199,080,000
1961	162,720,000

HIGHLIGHTS OF THE MAG COUNCIL MEETING SEPTEMBER 14-15, 1968

This summary is being published so that MAG Officers and Councilors may be advised of the actions of the Council between meetings of Council. It covers only major actions and is not intended as a detailed report in lieu of meeting minutes.

TREASURER'S REPORT—An appropriation of $750 was made from savings to defray the cost of caucuses and other incidentals at the AMA Clinical Session in December. In addition, $250 was appropriated for use in the Georgia Delegation's campaign to elect Dr. J. Frank Walker to the position of Vice Speaker of the AMA House of Delegates. The $95 cost of the County Society Executives' Dinner—meeting during the Committee Conclave—and a $225 expense budget for the Chairman of the Professional Conduct and Ethics Committee to attend the AMA National Congress on Ethics were also voted.

CALHOUN LECTURESHIP COMMITTEE—Dr. F. P. Calhoun, Jr., and Dr. Preston Ellington were appointed to the Calhoun Lectureship Committee with Dr. A. Calhoun Witham.

ANNUAL SESSION—The new format for Annual Sessions was unveiled by Annual Session Committee Chairman, Dr. Preston Ellington, and Council voted its approval.

FEDERATION LICENSING EXAMINATION (FLEX)—Council voted its approval of the report from Dr. J. Rhodes Haverty as Chairman of the Committee on Medical Education that the FLEX examination be recommended by MAG for adoption by the Georgia Board of Medical Examiners.

ROSTER AND OTHER JOURNAL SUPPLEMENTS—The Staff was directed to study the timing and contents of the MAG Roster and make recommendations to the October Executive Committee meeting.

HARDMAN AWARD BOWLS—After viewing the new awards for living past recipients of the Hardman Award, Council referred the matter of presentations to the Awards Committee for recommendation.

HEALTH CAREERS COUNCIL OF GEORGIA INC.—Council passed a motion directing the Committee on Finance to include a $5,000 contribution to HCCG in the next annual budget.

GaMPAC—After hearing a complete report of GaMPAC activities and plans, Council approved the request of Chairman, Dr. Earnest Atkins, that $1,500 be contributed to the GaMPAC Education Fund.

COMMITTEE CONCLAVE—The Staff was directed to proceed with arrangements for a second Committee Conclave to be held in 1969.

INFORMATION REPORTS RECEIVED ON: the awarding of a Title XIX Contract; the GRMP Operational Grant; MAG plea to enjoin the director of the Dept. of Public Health; replying to the Dean of Emory Medical School; liaison meetings with the Osteopathic Medical Assn.; actions of the State Board of Health; legislative matters, State and Federal; plans for the MAG Rural Health Conference, October 4-5, 1968; plans for the Medical Education Conference, February 28-March 2, 1969; progress of the building construction and loan; primary election results in Hart County and other locations.

HIGHLIGHTS OF EXECUTIVE COMMITTEE OF COUNCIL MEETINGS, SEPTEMBER 8 AND 14, 1968

This summary is being published so that MAG Officers and Councilors may be advised of the actions of the Executive Committee between meetings of Council. It covers only major actions and is not intended as a detailed report in lieu of meeting minutes.

CANCER REGISTRY CONTRACT—A contract with the National Cancer Institute to identify cancer patients in Georgia and to survey a given sample of those patients to evaluate the effects of socio-economic factors was approved. This three and one-half year survey will increase the MAG staff by nine employees and add some $80,000 to the Annual Budget.

TITLE XIX CONTRACT—Dr. Lamar B. Peacock, member of the State Board of Health, reported on the Board's action in awarding the contract for usual and customary fee certification and utilization review to Travelers Insurance Company. At the same time it was noted that MAG's contract to review all Title XIX hospital claims would be terminated September 30, 1968, as that project also was assumed by Travelers Insurance Company.

SUIT TO ENJOIN HEALTH DEPARTMENT DIRECTOR—Attorney John Moore advised that a decision on MAG's plea would probably be delayed for some time due to the press of cases presently before the court, but that pending a decision, a temporary injunction was in effect.

LIFE MEMBERSHIP—A new section defining MAG's Life Membership will be requested from the Constitution and Bylaws Committee, and will be discussed at a meeting early in 1969.

EMPLOYEE BENEFITS—A work rules revision was voted which will provide family Blue Cross-Blue Shield coverage for MAG employees who are heads of households.

NEW MEMBERS

Artress, George E., M.D. Active—Cobb	2356 Belmont Circle, S.E. Smyrna, Georgia 33080
Brown, Charles W., M.D. Active—Fulton	478 Peachtree Street, N.E. Atlanta, Georgia 30308
Brown, Howard S., M.D. Active—Fulton	1293 Peachtree Street, N.E. Atlanta, Georgia 30309
Butler, Walter H., M.D. Active—Fulton	1110 Vernon Springs Court, N.W. Atlanta, Georgia 30327
Cohn, Marvin H., M.D. Active—Fulton	35 Fourth Street, N.E. Atlanta, Georgia 30308
DeFoor, Joseph T., Jr., M.D. Active—Cobb	792 Church Street Marietta, Georgia 30060
Estes, Richard C., M.D. Active—Fulton	1938 Peachtree Road, N.W. Atlanta, Georgia 30309
Humphrey, Loren J., M.D. Active—Fulton	1365 Clifton Road, N.E. Atlanta, Georgia 30322
Jove, Donna F., M.D. Active—Fulton	3124-B Briarcliff Road, N.E. Atlanta, Georgia 30329
Jove, Julpo, M.D. Active—Fulton	3124-B Briarcliff Road, N.E. Atlanta, Georgia 30329
Lane, Donald R., M.D. DE-4—Fulton	Rogersville, Tennessee 37857
Layne, William T., M.D. Active—Cobb	3001 S. Cobb Drive Smyrna, Georgia 30080
McLean, Donald C., M.D. Active—Fulton	46 Fifth Street, N.E. Atlanta, Georgia 30308
McNinch, Joseph H., M.D. Active—Fulton	3379 Peachtree Road, N.E. Atlanta, Georgia 30326
Molkner, Kenneth C., M.D. Active—Fulton	3400 Peachtree Road, N.E. Atlanta, Georgia 30326
Pena, Leopold I., M.D. Active—Fulton	1293 Peachtree Street, N.E. Atlanta, Georgia 30309
Schnackenberg, Robert C., M.D. Active—Fulton	1317 Clifton Road, N.E. Atlanta, Georgia 30322
Watson, David T., M.D. Active—Fulton	384 Peachtree Street, N.E. Atlanta, Georgia 30308

SOCIETIES

Guest speakers at the summer meeting of the **Tenth District Medical Society** were Drs. Jack Lindley, Dewey Gray and Steve Brown. The subject of the program was a "Thyroid Symposium."

Members of the **Hall County Medical Society** heard a talk by Dr. Downa on the recent political changes in the private practice of medicine. Dr. Downa also discussed involvement in the model cities program.

Guest speaker at the September meeting of the **Glynn County Medical Society** was Mr. O'Hare, Director of the Glynn Paton School. Mr. O'Hare explained the re-organization of the school and the plans for the future.

Robert R. Smith was the guest speaker at the regular meeting of the **Richmond County Medical Society** on September 24. Dr. Smith is Associate Director, Georgia Regional Medical Program.

The **Sixth District Medical Society** held its winter meeting November 13 at Post 3, American Legion, Macon. A timely program on the use of radioisotopes in diagnosis was given by Wayne Bohannan, M.D., Radiology Associates of Macon. His subject was "The Diagnostic Potential of Scintillation Scanning."

PERSONALS

First District

L. H. Griffin, Sr. has announced that Josiah Thompson is now associated with him for the practice of surgery in Claxton.

Second District

At the 20th Annual Meeting of the Georgia Heart Association, **Thomas D. Johnson** of Albany was chosen president-elect. Other officers elected include **Dan Burge** of Atlanta, vice-president and **Harold W. Whiteman** of Atlanta, secretary.

Board members elected at the meeting include **Paul Teplis,** Atlanta; **Harry T. Harper, Jr.,** Augusta; **Henry S. Jennings, Jr.,** Gainesville; **John W. Looper,** Dalton; **Ernest E. Proctor,** Newnan; and **Leo Wade,** Union Point.

Albany internist **F. Dempsey Guillebeau** has been elected to membership in the American Society of Internal Medicine.

Third District

The new president of the Georgia Heart Association is **Simone Brocato** of Columbus, a former vice-president of the Medical Association of Georgia.

Luther H. Wolff, of Columbus, is the newly elected president of the Georgia Surgical Society. Dr. Wolff succeeds **James Thoroughman** of Atlanta. Also elected

at the recent meeting were **Charles H. Richardson** of Macon, vice-president, and **William G. Whitaker** of Atlanta, secretary-treasurer.

Fifth District

Emory University has announced the appointment of **E. Alan Paulk, Jr.** as assistant professor of medicine (cardiology), and **Asa G. Yancey** as assistant professor of surgery and assistant professor of preventive medicine.

James V. Rogers of Atlanta addressed members of the American Roentgen Ray Society during its annual meeting October 1-4 in New Orleans. His topic was "Calcification of the Tricuspid Annulus."

The newly elected chief of Staff at St. Joseph's Infirmary is **William F. Friedewald** of Atlanta.

John T. Godwin of Atlanta has been appointed to succeed **Jack C. Norris** of Atlanta as a member of the Workmen's Compensation Medical Board, State of Georgia.

Robert L. Egan, of Emory University, spoke before the sixth National Cancer Conference on his results of x-ray treatment for the early detection of breast cancer.

Dr. and Mrs. **Don Minor,** of Atlanta, attended a two week meeting of the Soviet-American Congress of Radiology. Meetings were held in Moscow, Leningrad, Budapest and Vienna.

Raymond G. Hicks, of Atlanta, was recently elected a Fellow of the American College of Anesthesiologists.

Two Atlanta physicians spoke before the Tennessee Academy of General Practice at the annual meeting November 7-8. **Fred L. Allman, Jr.** discussed "Strains and Sprains," and **John S. Turner, Jr.,** of Emory University School of Medicine, presented a paper on "Middle Ear Disease."

Sixth District

Lovick E. Dickey, of Macon, has returned from the Dominican Republic where he spent a month as a MEDICO volunteer. Dr. Dickey was stationed at the Jose Maria Cabral Beez Hospital in Santo Domingo.

Central State Hospital has announced the appointment of **John W. Kemble** as assistant superintendent—education, training and research.

Seventh District

At a recent meeting of the Calhoun Rotary Club, **R. D. Walter** discussed the American Academy of General Practice. Dr. Walter reviewed the history and objectives of the organization.

Eighth District

James C. Dismuke, of Adel, a member of the Board of Directors of the Georgia Academy of General Practice has returned from the annual scientific assembly of the American Academy of General Practice. The meeting was held in Las Vegas.

William C. Sams of Ocilla has been elected to active membership in the American Academy of General Practice.

Tenth District

An Augusta physician, **Stephen W. Brown,** was installed as president of the American Roentgen Ray Society at the Society's annual meeting in New Orleans. Society members also heard **Mark Brown** present a paper on "Neutron Radiography in Biological Media."

Robert B. Greenblatt, of Augusta, spoke before the Augusta Exchange Club on "Sex Life After Forty."

DEATHS

Ernest Corn

Ernest Corn, widely known Macon physician, died August 27 in a Macon hospital.

Dr. Corn was born in Hiawassee, Georgia, September 18, 1887, and was educated at Hiawassee Junior College and Emory University. He received his medical degree from Emory in 1916.

During World War I, he served at base hospitals in France and in the Army of Occupation in Germany. He returned to Macon where he practiced urology for 50 years. He was on the staffs at the Macon Hospital and the Middle Georgia Hospital before retiring two years ago.

Dr. Corn was a Fellow of the American College of Surgeons, the Medical Association of Georgia and the Bibb County Medical Society.

Survivors include his wife the former Pauline Pierce: five children, Mrs. George C. Felton of Macon; Lovick Pierce Corn of Columbus; Thomas Lewis Corn of San Francisco; Mrs. James Steward Conway of Paris, France and Charles Philip Corn of Washington, D.C.; three sisters, Mrs. William Hopkins of Decatur, Mrs. Thomas Telford of Maysville and Mrs. Henry Grady of Montevallo, Ala.; one brother Leonard Corn of Warne, N.C., and several nieces, nephews and grandchildren.

Charles R. Smith

A Columbus psychiatrist, Charles R. Smith, died of a heart attack September 1 in Mexico City while on a visit there with his wife and two of his sons. Dr. Smith was 53.

He was born in Rosenberg, Texas and attended Hardin-Simmons University and Texas Technological College. In 1938 he received his medical degree from the University of Texas School of Medicine. In 1946 he moved to Columbus and practiced general medicine for two years before limiting his practice to psychiatry.

Dr. Smith was chief of psychiatric service at The Medical Center, St. Francis Hospital and Cobb Memorial Hospital, and served as consultant to the Muscogee County Health Department and the Georgia Department of Public Health.

He was a member of the Muscogee County Medical Society, the Medical Association of Georgia, the Georgia Psychiatric Association (of which he was president in 1963-64), the Southern Psychiatric Association and the American Psychiatric Association.

Survivors include his wife Mrs. Myrtle Oglesby Smith, and three sons, Charles, Jr., Richard O. Smith and Michael O. Smith.

John Lowell Thomas

A Rincon physician, John Lowell Thomas died September 11 at the age of 36.

A native of West Palm Beach, Florida, Dr. Thomas was graduated from Wake Forest College, and the Medical College of Georgia. He served his intern-

ship at the University Hospital in Augusta and worked for 18 months at the Georgia Training School at Gracewood. In 1960, he began his practice at Port Wentworth and in 1964, established his practice at Rincon.

Surviving Dr. Thomas are his wife Dr. Ruth McMinn Thomas, a son John Lowell Thomas II, three daughters, Carolyn, Patsy and Charlotte Thomas; a brother Nelson Cole Thomas of California, and a number of aunts and uncles.

Charles Hadley Allen

Charles Hadley Allen of Bremen died in an Atlanta hospital on September 18 at the age of 56.

Dr. Allen was graduated from the Medical College of Georgia in 1936 and began his medical practice in Bremen in 1939. In 1958 he became chief of staff of the new Bremen General Hospital and the Bremen Medical Clinic.

He was a member of the Haralson-Douglas-Carroll Medical Society, the Medical Society of Georgia, the Haralson County Chapter of the American Red Cross (of which he was a former chapter chairman), and the Board of Health of Haralson County (of which he was chairman).

Survivors include his wife Mrs. Elizabeth Jane Allen, a daughter Lt. Elizabeth Jane Allen of Norfolk, Va.; a son, William Hadley Allen, Bremen; his mother Mrs. Charles S. Allen, Bremen; and a brother, Dr. Lane Allen, Augusta.

Wayne Starr Aiken

Wayne Starr Aiken, 75, died at his home in Atlanta on October 2. Dr. Aiken was the first graduate of the Emory University School of Medicine when he received his medical degree in 1915. He was chief of the house surgical staff at Memorial Hospital in Richmond until 1916.

Upon returning to Atlanta, he was made chief physician and surgeon for the Georgia Power Co., where he worked until 1920, when he established a practice in plastic surgery at the Atlanta Southern Dental College, now a branch of Emory University. Dr. Aiken was widely known as the first physician in the Atlanta area to administer intravenous anesthesia and spinal anesthesia.

In 1946, Dr. Aiken was presented a Certificate of Distinction from the Fulton County Medical Society for 25 years of "faithful and continuous membership" in the society. In 1965, he received a Certificate of Distinction from the Medical Association of Georgia for "50 years of proficient and untiring ministry in the science of the unselfish devotion to his patients and loyalty to the medical profession." He held life memberships in the Medical Association of Georgia and the American Medical Association.

Surviving Dr. Aiken are his wife, the former Effie Parker; three daughters, Mrs. Rea C. Tenney of Houston, Mrs. William J. Pendergrast of Atlanta, and Mrs. Charles A. Burdell, also of Atlanta; four sisters, Mrs. John H. Chafin of McDonough, Mrs. G. R. Foster, Sr. and Mrs. Robert Earle King, both of Atlanta, and Mrs. Andrew T. Sheils of Columbus; and three brothers, G. Seals Aiken and Dr. Ralph H. Aiken, both of Atlanta, and Charles P. Aiken of Columbia.

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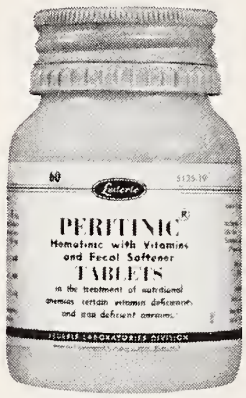

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THE MONTH IN WASHINGTON

The American Medical Association protested strongly against proposed new medicaid regulations affecting payments to physicians and utilization review. The proposed regulation on physicians' reasonable charges was described as an anomaly in a protest to the Department of Health, Education and Welfare.

Regulation Termed an Anomaly

In the protest filed with the Department of Health, Education and Welfare, the AMA termed the proposed regulation on physicians' "reasonable" charges as an anomaly because it is based on payments received with no consideration given to the usual and customary fee.

Since medicare payments made by the government are 80 per cent of the reasonable charge, this amount could become the maximum of every charge under medicare, the AMA said. Or, were physicians to receive less than full payment and write off losses, the reduced payments could become the basis for the reasonable charge under medicaid.

The new regulation on utilization review would require a State medicaid plan to provide for utilization review of each item of service, including a physician's in his office or the patient's home. The AMA said it could lead to a set of national standards with authorized treatment for each medical condition limited in a manner set by regulation

The AMA said it is not opposed to a "claims review" process to that now in operation in many areas or as conducted under medicare. Nor, the AMA added, did it find fault with inquiring into a physician's conduct where fraud is alleged, or where it appears on the basis of medicare claims submitted, that there is reasonable ground for further investigation of a possible fraud.

Financing Comprehensive Care

In another development, the Advisory Commission on Intergovernmental Relations supported a medicaid goal of comprehensive health care for the needy and medically needy by 1957, but proposed changes in financing and operation of the Federal-State program.

The report was directed particularly to "the virtually unmanageable fiscal burden imposed on State and local governments by the program." It urged that consideration be given to "broadening medicaid's financial base through increased involvement of the private sector through an employer-employee contributory health insurance system." If Congress approved this proposal, it would be a giant step toward national compulsory government health insurance.

The commission rejected proposals to limit Federal sharing in medicare and to establish national eligibility standards for beneficiaries.

The report was made public soon after the Senate voted a $500 million cutback in medicaid funds and when some States already were trimming their medicaid programs because of a financial pinch.

Commission Recommendations

The commission recommended that the States "move vigorously to experiment with methods of increasing the efficiency and economy of health services under the

medicaid program," including: (1) Reimbursing hospitals contingent on their operating under an acceptable standard of management efficiency; (2) expanding prior authorization for elective surgical procedures; (3) payment for physicians' services on a basis other than usual and customary charges; (4) use of co-payments for the purchase of specified health care services; and (5) improved techniques of utilization review.

The 26-member Commission is a bipartisan body established by Federal law in 1959 to maintain continuing review of the relations among Federal, State and local governments. Its membership consists of Governors, mayors, county officials, State legislators, and representatives of both houses of Congress, the Federal executive branch, and the general public. The chairman is Farris Bryant, former Governor of Florida.

Programs Extended

Congress approved a two-year extension of the regional medical programs and a one-year extension of the Hill-Burton program of Federal aid for construction of hospitals and other health care facilities.

The legislation authorizes appropriation of $65 million in this fiscal year, ending next June 30, and $120 million for the next year for the regional medical programs. The Senate had voted a three-year extension but it was dropped in a House-Senate conference which worked out the compromise.

The Hill-Burton program was authorized $195 million for hospitals and $100 million for other health care facilities. The conferees abandoned Senate provisions for a new three-year program of Federal loans of $200 million a year for hospital modernization and a guaranteed loan program of the same amount with a Federal subsidy of interest. These provisions also were left for further consideration by the next Congress.

Narcotics Addicts and Alcoholics

A total of $40 million was authorized for two years for construction and staffing of rehabilitation facilities for narcotics addicts and alcoholics. As a declaration of Congress, the measure states:

"Alcoholism is a major health and social problem afflicting a significant proportion of the public and much more needs to be done by public and private agencies to develop effective prevention and control."

The program of grants for family health service clinics for migratory agricultural workers was extended for two years with $9 million authorized for the current fiscal year and $15 million for the next year.

Family Health Week

Congress approved legislation designating Nov. 17-23 as "National Family Health Week." The legislation termed the week "as a means of focusing national attention during the year upon the accomplishments of the American health care system and the central role played by the family physician in the maintenance of superior medical care for Americans of all ages and from all walks of life."

Training Ambulance Personnel

The Committee on Emergency Medical Services of the National Research Council has recommended establishment of a nationwide program for the training of ambulance personnel.

The committee proposed guidelines for such training,

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stating that there is at present "no uniformity in the course of instruction and . . . no generally accepted standards of proficiency to be used by those empowered to certify ambulance personnel."

The committee's recommended guidelines cover: either the standard or advanced first aid courses of the American National Red Cross as a prerequisite; the operation of emergency vehicles; safety precautions at the accident scene; priorities of care; records; the use of communication systems; the use of equipment and supplies; medicolegal problems, and rescue procedures.

The levels of proficiency designed to result from the course proposed in the report are attainable in most areas of the country within a reasonable time, the committee said. However, to realize the greatest life-saving potential, the ambulance attendant of the future should be trained to the same level as lay assistants in emergency departments or medical corpsmen in combat areas; and, ideally he should be qualified to carry out, either independently or through voice communication with a physician, such procedures as tracheostomy, defibrillation, and mechanical external cardiac compression, the committee said.

Establish Hospital Programs

To attain these goals, the committee said, accredited hospital training programs must be established that will produce professional ambulance attendants and emergency department assistants of the caliber of certified X-ray, laboratory, physical therapy, and other accredited medical technicians

The ambulance attendant, it added, must be fully engaged in emergency care in an established career pattern that provides attractive compensation, prestige, and recognition deserving of his services as a member of the emergency care team. Where the needs for ambulance services are low so that he is not fully occupied, such as in small communities, he should be an employee of a hospital, where he can maintain his interest and proficiency as an assistant in the emergency department, intensive-care unit, or operating room, the committee said.

Mental Retardation Report

The President's Committee on Mental Retardation reported that three-fourths of the nation's 6,000,000 mentally retarded live in urban ghettos and rural slums and were unwanted, unplanned children.

The committee's second annual report, entitled "The Edge of Change," dealt with the high incidence of retarded development among the poor, the shortage of man power to serve the retarded, and the low quality of residential care available to most of them.

The committee's recommendations called for:

—Education and health services for every child from birth.

—An insurance system to give parents a free choice in selecting needed services.

—Development of national accreditation standards for residential facilities for the retarded.

—Voluntary family planning services for all Americans.

From the Washington Office, American Medical Association, October 2, 1968.

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MEDICO needs several gynecologists to assist in its volunteer programs overseas during the ensuing twelve months. Help is greatly desired in Afghanistan, and also in the Dominican Republic, Honduras, and Malaysia. Information may be obtained by writing MEDICO, 2007 Eye Street, N.W., Washington, D.C. 20006, or to CARE-MEDICO, 660 First Avenue, New York, New York 10016.

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CALENDAR OF MEETINGS

In Georgia

November 15-16—Georgia Academy of General Practice, DeSoto Hilton Hotel, Savannah, Ga.

December 5-8—American Rheumatism Association, Regency-Hyatt House, Atlanta.

February 18-22, 1969—American College of Radiology, Regency-Hyatt House, Atlanta.

February 23-26—Atlanta Graduate Medical Assembly, Regency-Hyatt House, Atlanta.

March 14-15—American Burn Association, Regency-Hyatt House, Atlanta.

March 27-29—Southern Society of Anesthesiologists, Marriott Motor Hotel, Atlanta.

May 4-7—115th MAG Annual Session, Savannah Inn and Country Club, Savannah.

National

November 17-20—APhA Academy of Pharmaceutical Sciences, Statler Hilton Hotel, Washington, D.C.

November 18-21—Southern Medical Association, The Rivergate, New Orleans, La.

November 19-20—Council on Arteriosclerosis, Balmoral Hotel, Bal Harbour, Fla.

November 20-22—National Society for the Prevention of Blindness, Inc., Roosevelt Hotel, New York, N.Y.

November 21-26—American Heart Association, Americana Hotel, Bal Harbour, Fla.

November 22-23—Southern Society for Pediatric Research, Roosevelt Hotel, New Orleans, La.

November 29-30—National Federation of Catholic Physicians' Guilds, Miami Beach, Fla.

November 29-30—Symposium on Membrane Proteins (Sponsored by the New York Heart Association), Biltmore Hotel, New York, N.Y.

November 30—AMA National Conference on Community Health Planning, Statler Hilton Hotel, Miami Beach, Fla.

December 1—American Academy of Oral Medicine, Park Sheraton Hotel, New York, N.Y.

December 1—AMA National Conference on Medical Aspects of Sports, Hotel Deauville, Miami Beach, Fla.

December 1-4—American Medical Association, Clinical Convention, Miami Beach, Fla.

December 1-6—Radiological Society of America, Chicago, Ill.

December 1-7—International Congress of Pediatrics, Mexico City, Mex.

December 2-4—Education Foundation of American Society of Plastic and Reconstructive Surgery, Chatham Center, Pittsburgh, Pa.

December 4-7—American Medical Women's Association, Statler-Hilton Hotel, Boston, Mass.

December 6-7—American Federation for Clinical Research, Somerset Hotel, Boston, Mass.

December 7-12—American Academy of Dermatology, Palmer House, Chicago, Ill.

December 9-11—Southern Surgical Association, Boca Raton Hotel and Club, Boca Raton, Fla.

December 10-14—American Academy for Cerebral Palsy, Americana Hotel, Bal Harbour, Fla.

December 13-15—American Academy of Psychoanalysis, Royal Orleans Hotel, New Orleans, La.

December 20-22—American Psychoanalytic Association, Waldorf Astoria Hotel, New York, N.Y.

1969

January 17-18—American Society for Surgery of the Hand, Americana Hotel, New York, N.Y.

January 18-23—American Academy of Orthopaedic Surgeons, Americana Hotel, New York, N.Y.

January 23-24—Southern Society for Clinical Investigation, Jung Hotel, New Orleans, La.

January 31-February 2—Southern Radiological Conference, Grand Hotel, Point Clear, Ala.

February 5-7—American Academy of Occupational Medicine, Sheraton Plaza Hotel, Boston, Mass.

February 8-13—International Academy of Proctology (Annual Congress and Teaching Seminar), Hollywood Beach Hotel, Hollywood, Fla.

February 9-10—Congress on Medical Education, Palmer House, Chicago, Ill.

February 13-15—Society of University Surgeons, Hotel Fontainebleau, Miami Beach, Fla.

February 26-March 2—American College of Cardiology, New York Hilton, New York, N.Y.

PROGRAM OFFERED IN FAMILY MEDICINE

The Departments of Medicine at the Peter Bent Brigham Hospital and the Children's Hospital Medical Center, Boston, have established a residency program in family medicine. The first two years would be spent on the inpatient services of the two institutions with the third year in the Family Health Care Program. The goal of the training program is to extend the physician's basic clinical knowledge and experience with family medical problems.

For information write: Joel J. Alpert, M.D., Medical Director, Family Health Care Program, 83 Francis Street, Boston 02115.

POSTGRADUATE COURSE IN OPHTHALMOLOGY IS SET

On December 5-6, Emory University will present its annual Postgraduate Course in Ophthalmology at Grady Memorial Hospital in Atlanta. For additional information, write F. Phinizy Calhoun, Jr., M.D., Emory University Clinic, 1365 Clifton Road, N.E., Atlanta, Ga. 30322.

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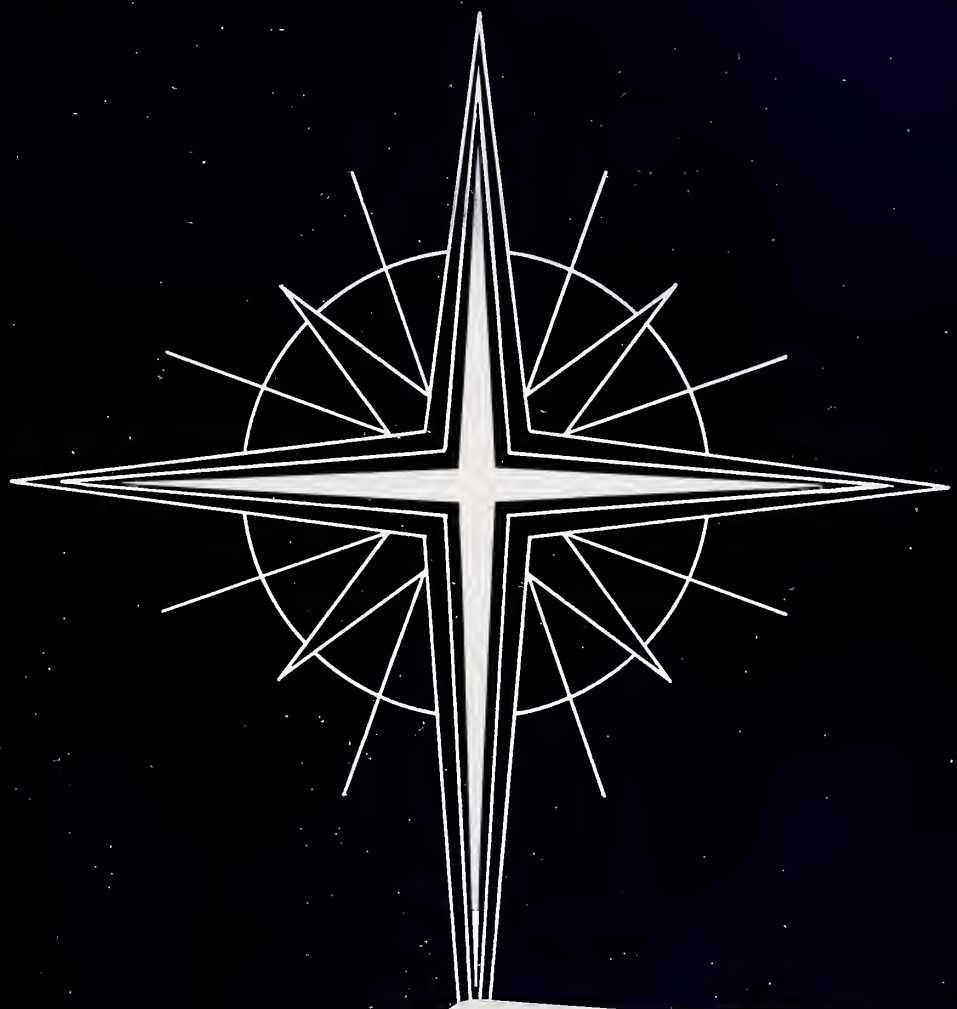
Plan now to join your colleagues in Miami Beach. Be sure to look for the complete scientific program, plus forms for advance registration and hotel accommodations in the October 21st issue of JAMA.

JOURNAL OF THE MEDICAL ASSOCIATION Georgia
DECEMBER / 1968



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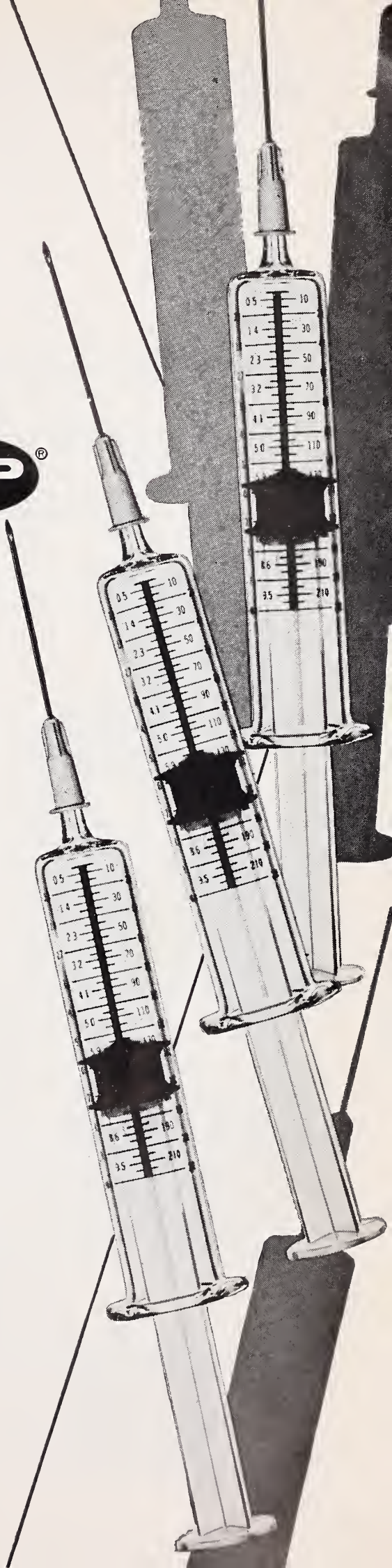

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DECEMBER 1968 *Volume 57, Number 12*

JOURNAL OF THE MEDICAL ASSOCIATION Georgia

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JOURNAL OF THE MEDICAL ASSOCIATION Georgia

Various disease entities will have characteristic abnormal fluorescein angiographic patterns.

The Use of Fluorescence Retinal Photography in the Diagnosis and Treatment of Macular Disease

PAUL C. WETZIG, M.D. *and* C. NEAL JEPSON, M.D., *Colorado Springs, Colorado*

SINCE THE INTRODUCTION of fluorescence photography by Novotny and Alvis in 1961, tremendous interest has arisen in the use of this new technique in the diagnosis of various diseases of the ocular fundus. The technique has introduced a new, dynamic method of visualizing structures which previously were obscure. It has not only proved to be an invaluable research tool in the investigation of the circulation in the eyes, but has also proved to be of practical use to the clinical ophthalmologist in helping to understand the pathogenesis of various ocular diseases. It has also helped to form new concepts in the treatment of these diseases.

Phenomenon of Fluorescence

The phenomenon of fluorescence is based upon the fact that certain substances will absorb light in one wave length and then emit them in another. The dye sodium fluorescein absorbs light in the blue range of the spectrum and then emits it in the green range. When fluorescein is injected into the intravenous circulation and a powerful blue light is transmitted into the ocular fundus, the outline of the circulating fluorescein appears green, thus outlining the pattern of the retinal circulation. When the ocular fundus is viewed with ordinary examining instruments, which utilize transmitted light, only the superficial structures can be seen because the light is reflected from the first reflecting surface.

Circulatory Pattern

When the ocular fundus is viewed utilizing blue light, after the intravenous injection of fluorescein, the deeper vascular structures of the choroid and retina may be seen. The circulatory pattern in the normal eye follows a characteristic time sequence. Approximately seven seconds following the injection of sodium fluorescein into the antecubital vein of the forearm the entire background of the fundus appears to be lighted as the dye enters the choroidal circulation first. About one half second later the arteries appear to fill. Next the veins begin to fluoresce and the fluorescence in the arterioles becomes less pronounced. In the later phases both the arteries and the veins are empty of dye and some dye remains pooled in the choroidal vascular structures.

The dye does not diffuse out of the retinal capillaries as it does in other parts of the body. This renders it particularly useful in fluorescein retinal angiography. The choroidal blood supply to the macular region is covered by a dense layer of pigment epithelium. This pigmented layer obscures the view of the circulating dye in the choriocapillaris. Therefore, this area remains dark during the circulation of the dye.

Any deviation in this pattern, whether it be obstruction to circulation, delayed circulation time,

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leakage of fluorescein from the capillaries or its appearance through the pigment epithelium is regarded as being abnormal. It has been observed that various disease entities will have characteristic abnormal fluorescein angiographic patterns.

This phenomenon can be observed utilizing either the direct or indirect ophthalmoscope with proper filters. Since the passage of the dye through the retinal circulation is rapid, it is best to record the pattern photographically, so that it can be studied in more detail.

Technique Outlined

The technique that we have used is as follows: In the eye to be examined the pupil is widely dilated. The patient is positioned before the Zeiss retinal camera. This camera has been specially fitted with filters to provide a powerful blue light source going into the eye. The camera has been equipped with a barrier filter to eliminate nearly all light except the green light coming onto the photographic film. Both color and black and white photos may be made using various types of high speed film. The camera is also equipped with a rapid cycling device so that light may be delivered into the eye at less than one second intervals.

Five cc. of ten per cent sodium fluorescein solution is then injected into the antecubital vein of the forearm. After approximately seven seconds there appears to be an overall increase in illumination of the fundus, which signals the appearance of the dye in the choroidal circulation. At this time rapid sequence photography is begun. Following the emptying of the veins, the time interval is lengthened to 5 minutes. Photography is usually carried out for a total of thirty minutes.

Few Adverse Effects

Very few adverse effects have been encountered with this technique. Rarely will a patient experience nausea and vomiting. Some have experienced a mild syncope.

Most Maculopathy Is Secondary

It has long been observed that most maculopathy does not arise within the macula itself, but is usually secondary to diseased para-macula structures. The value of light coagulation in the treatment of macular disease is based upon the concept that an artificially produced chororetinal scar may form a barrier protecting the macula against the invasion of these abnormal processes, thereby preserving macular function.

In carrying out this procedure, the point of fixation is first determined with the visuscope and this area is then scrupulously avoided in the treatment. The area of abnormality has been previously outlined by retinal fluorescence angiography and the treatment is primarily directed toward this area.

Effect on Vision

A semi-circular pattern of light coagulation may be applied around the macula without the patient being aware of any change in his visual status. Temporarily there is a dark scotoma, but this eventually disappears. Some defects in the field have been noted when the application is too close to the macula.

The fluorescein retinal pattern may give an indication of what macular diseases may benefit from this procedure. When there is a diffuse abnormality involving the macular region this procedure will be of no value; however, if discrete areas of abnormality are seen in the para-macular region, the treatment may be of some benefit. In the primary retinal degenerative changes, which are characterized by degeneration of the retinal elements, there appears a characteristic fluorescent pattern, due to the destruction of the pigment epithelium. This type of disorder does not benefit by light coagulation treatment.

Hemorrhagic Type

In the hemorrhagic, exudative type (Kuhnt-Junius), which is characterized by its exacerbation and remissions, there is a characteristic fluorescent pattern. This is manifested by scattered areas of fluorescein diffusing into the para-macular region. When these areas have been treated by light coagulation there appears to be a remission of the acute process and the secondary macular edema may absorb with subsequent improvement in vision, which sometimes appears to be permanent.

The so-called entity of "detachment of the retinal pigment epithelium" demonstrates a characteristic fluorescent pattern. The cystic detached area demonstrates a discrete filling of fluorescein in the late post-venous phase. This cystic area may be obliterated by light coagulation thereby retarding its spread into the macula.

Histoplasmosis Retinopathy

The fluorescent pattern in the presumed histoplasmosis retinopathy gives a characteristic pattern. A discrete para-macular fluorescence may be seen. which is associated with hemorrhagic exudative macular involvement. Benefit has been reported by treating this para-macular focus by light coagulation.

Central Serous Retinopathy

Central serous retinopathy gives a characteristic picture and a dramatic response to light coagulation

therapy. In this entity a small para-macular area of fluorescein pooling may be seen very late after the venous phase. When this is treated, the exudative picture in the macula may disappear within 24 hours.

Angiomatosis

Angiomatosis demonstrates a filling of the tumors in the arterial phase and the outlines of the vascular abnormalities may be discretely outlined and subsequently destroyed.

Coats' Disease

The pattern in Coats' disease demonstrates a more diffuse, unpredictable picture. However, it also lends itself well to light coagulation therapy.

It has been observed that the occurrence of retinal vein occlusion may precede visual disturbances by a long latent time period. The visual disturbances may often be secondary to edema of the macula resulting from the venous stasis. When this is seen before the macula has become involved, the macula may be shielded by a protective barrier of chorioretinal burns and vision preserved.

Role of the Vitreous Is Obscure

The role of the vitreous in the production of maculopathy is obscure. However, in the entity of "macular pucker" a venous stasis and diffusion of fluorescein from the capillaries may be demonstrated. It is possible that photocoagulation may free such areas of vitreous traction and we have attempted to do so in several cases. The merits of this require more investigation.

Summary

In summary it may be stated that fluorescence retinal photography is a new, valuable method of viewing the ocular fundus which allows visualization of the retinal and choroidal circulation. Deviations from the normal patterns are useful in classifying various macular diseases. The use of light coagulation is based upon the principle of the production of a mechanical chorioretinal scar which may shield against the advances of disease in para-macular structures, hopefully, thereby, preserving macular function.

Colorado Springs Eye Clinic

DRUG GROUPS FORM INTERNATIONAL FEDERATION

An international body of drug industry associations has been formed to work toward the understanding and solution of world-wide health problems. "By fostering international cooperation, this new federation will contribute to advancing the health and welfare of peoples around the world," according to C. Joseph Stetler, president, Pharmaceutical Manufacturers Association.

Stetler is one of two Americans on the seven-man council of the newly-formed International Federation of Pharmaceutical Manufacturers Associations. The other is William H. Conzen, president of the Schering Corporation. They represent the PMA, one of the four founding associations.

Objectives of the Federation

One of the objectives of the Federation, Stetler explained, is to assist where possible in broad programs that involve the production and distribution of drugs, and "especially in the underdeveloped countries where the lack is greatest."

Another objective is to promote the further development of ethical principles and practices throughout the pharmaceutical industry world-wide. "This means we will strengthen and develop contacts with national and international organizations, within both government and the private sector," Stetler said. Pharmaceutical associations in all parts of the globe will be invited to become members.

Future Projects

Among areas of interest in the foreseeable future will be drug testing laboratories, reporting procedures for adverse drug reactions, advertising codes, international quality control standards, and good manufacturing practices, as well as technological aid to such international groups as the World Health Organization.

Plans for the Federation were virtually completed during a conference in Stockholm in June attended by delegates of the PMA; the Pharmaceutical Manufacturers Association of Canada (PMAC); le Groupement International de l'Industrie Pharmaceutique (GIIP); the drug industry Association for the Common Market countries; and the Pharmaceutical Industries Association (PIA), representing countries of the European Free Trade Area.

Six Years of Planning

These four organizations have been meeting together since 1962 to discuss common problems and exchange information on regulatory and scientific advances in drug therapy. The Federation, which became official on August 1, 1968, consists of an Assembly, which will meet annually, and a Council, with two representatives each from the GIIP, PIA, PMA, and one from the PMAC.

First president of the IFPMA is Dr. H. Harms of the GIIP, with PMA's Stetler and F. W. Griffin of PIA as vice presidents. Other members of the Council are B. Olivier-Martin of GIIP, E. Goth of PIA and Dr. William W. Wigle, president of the PMAC.

The first annual meeting of the Assembly will be held in Rome, May 29-30, 1969.

This report outlines the role of cardiac pacing in the treatment of some abnormal rhythms associated with infarction.

Indications for Cardiac Pacing in Acute Myocardial Infarction

PHILIP SAMET, M.D., *Miami Beach, Florida**

CONGESTIVE HEART FAILURE, shock and cardiac arrhythmias with rapid or slow ventricular rates are three complications of acute myocardial infarction resulting in increased mortality.

Sinus bradycardia occurs in 11-14 per cent of patients with acute myocardial infarction. First and second degree atrioventricular block have been observed in 12-23 per cent, and third degree or complete atrioventricular block in two to eight per cent of patients with acute infarction. Complete heart block was associated with a mortality rate of 58-100 per cent prior to the era of pervenous cardiac pacing. The lesser degrees of atrioventricular block are potential warnings of complete heart block and carry a high risk of ventricular standstill, ventricular tachycardia and ventricular fibrillation. Sinus bradycardia is probably also associated with ventricular asystole and the varied grades of atrioventricular block.

Preference for Catheter Pacing

Since the initial report on the use of the pervenous temporary catheter electrode for the treatment of slow ventricular rates caused by complete heart block complicating acute myocardial infarction, a number of observers have employed catheter pacing under similar circumstances, in preference to drug therapy with isuprel or atropine. It must be stressed that spontaneous reversion to normal sinus rhythm occurs in the majority of patients with complete heart block complicating acute myocardial infarction. For this reason the recent development of the standby or demand pacing mode is of great practical importance.

Avoiding Competitive Stimulation

In this mode of pacing, an effective pacing stimulus results only when a QRS complex is absent for a preset, predetermined interval. For example, if the demand interval is set at 60 beats/min., a pacer stimulus results if a QRS complex is absent for more than 1 second; if the demand interval is set at 30, a stimulus results if the QRS complex is absent for more than two seconds; if the demand interval is set at 120 per minute, a stimulus results if the QRS complex is absent for more than 0.5 seconds. Competitive stimulation between the pacer stimuli and the patient's own QRS complex is thus avoided. reducing or abolishing the possibility of repetitive ventricular rhythms (ventricular tachycardia or fibrillation) if a pacer stimulus happens to fall on the apex of a T wave during the so-called vulnerable period. The latter may readily occur if fixed rate pacers are employed with transient complete heart block. The demand pacer impulse is generally set at 2-3 times the threshold level to minimize further the possibility of repetitive ventricular firing.

Demand pacers are now readily available from a number of companies. External pacing plays little

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Prepared by the Georgia Heart Association for this Journal.

part today in the therapy of complete heart block with or without the complication of acute myocardial infarction.

Temporary Pervenous Pacing

The technique of temporary catheter passage deserves comment. A variety of veins may be employed to afford catheter passage—the cephalic or basilic veins, the subclavian, saphenous or external jugular veins. Since the latter vessel is often utilized for permanent catheter passage, we prefer to use the median basilic veins for temporary pervenous pacing. Catheter displacement within the right ventricular chamber is not a significant problem when arm veins are employed. We usually do not employ the blind method of passage of electrode catheters. An image amplifier fluoroscope located in the cardiac catheterization laboratory is used if the patient can be moved.

"Blind" Passage

If the patient cannot be moved, "blind" passage with a bipolar catheter has been attempted in the past, using the tip of the catheter as an exploring intracavity lead to check position; the latter approach is successful in 75 per cent of patients in experienced hands. A portable image amplifier is now available for bedside use and obviates the necessity for blind passage in patients who cannot be moved to the catheterization laboratory.

We have utilized only bipolar catheters with the tip placed either in the right ventricular outflow tract or the right ventricular apex. The thin platinum-tipped wires recently recommended by some cardiologists are not employed because of difficulty in blind passage and the danger of knot formation.

On rare occasions, in emergency situations, a transthoracic wire may be utilized to permit rapid ventricular capture by direct left ventricular needle puncture and passage of the pacing wire through the needle into the left ventricle.

Second Degree Block

The above discussion refers primarily to cardiac pacing in complete heart block. A few clinicians advocate initial therapy with atropine or isuprel for second degree atrioventricular block; if these fail, cardiac pacing is utilized. We utilize initial pacer therapy, as do most cardiologists. To avoid competitive rhythm, demand standby pacing is again the treatment of choice. Fixed rate pacers are especially contraindicated under these circumstances because of the danger of repetitive ventricular rhythms with ventricular fibrillation.

On the other hand, first degree atrioventricular block per se (without any other arrhythmia) is not treated by cardiac pacing, but is continuously, carefully monitored.

Sinus Bradycardia

Sinus bradycardia often requires pacer therapy. If the rate is between 50-60, atropine or isuprel therapy is carefully utilized in our institution since these agents may slow the ventricular rate while increasing the atrial rate. If the rate falls below 50/minute, a bipolar catheter is passed into the right atrium by techniques similar to those described above and set on atrial demand pacing modes at a rate of 60-70. Since atrioventricular conduction per se is normal under these circumstances, the ventricular rate is also 60-70.

If any degree of atrioventricular block is present along with sinus bradycardia, the electrode tip catheter is passed into the right ventricle for right ventricular demand pacing at a rate of 70-75. Nodal rhythm below rates of 60 is also treated by right ventricular demand pacing at rates of 70-75.

Concept of Overdriving

The most recent development in catheter electrode pacing in acute myocardial infarction patients involves the concept of overdriving. Despite the availability of digitalis, quinidine, procainamide, xylocaine, propranolol, etc., some patients with episodic atrial and ventricular tachycardias continue to pose a clinical problem. The cardiac pacing catheter has been utilized both on a temporary and permanent basis to overdrive the heart (by either atrial or ventricular pacing) at rates greater than the sinus rate to prevent such ectopic rhythms. It must be emphasized that the use of the pacing catheter under these circumstances is *not* for patients with atrioventricular block but for patients with varied types of atrial and ventricular arrhythmias. The ultimate usefulness of this latter type of pacing remains to be established.

ACP PRESENTS COURSE ON TOTAL CANCER CARE

The American College of Physicians will present a postgraduate course on "The Internist and Total Cancer Care," January 20-24, 1969, at the McGregor Memorial Community Arts Center, Wayne State University, Detroit, Michigan.

This course is aimed toward preparing internists to meet their responsibilities in total cancer care. A thorough grounding in theoretical principles, plus intensive teaching in practical medical oncology will be provided.

For further information, applications and registrations, write Edward C. Resenow, Jr., F.A.C.P., Executive Director, American College of Physicians, 4200 Pine Street, Philadelphia, Penn. 19104.

This paper presents the viewpoint and experience of the author who has been interested in the problem of skin cancer in the past four decades.

The Treatment of Skin Cancer

WILEY M. SAMS, M.D., *Miami, Florida*

SKIN CANCER CONTINUES TO BE a subject of widening interest for an ever increasing group of physicians. It is understandable that this should be the case, for we can only expect that the incidence will increase with the extension of the life span. Furthermore, with modern transportation and the provision of medical services to the older age group, we can expect to see fewer of the neglected patients who are problems, and an increasing number of those who will consult us with early and minimal lesions which will test, at times, our diagnostic acumen. Both physicians who treat these patients and carriers who process and adjust the claims will face an increased demand for the treatment of banal lesions which are benign and occur with the march of time. It is our problem to determine which lesions need treatment and to determine how it may be carried out most expediently. We cannot otherwise cope with the rising demand and furnish the needed medical care with the manpower now available for professional services.

Shortage of Medical Care

There has perhaps always been too little expert medical care, and this has tended to reach explosive proportions with the population increase and the expansion of medical knowledge which has taken place so rapidly in the past two decades. The shortage of medical service has been accelerated by scientific advances which have withdrawn an increasing number of physicians to investigative fields while others have been recruited for administrative duties with the social changes in the distribution of medical care. A review of the history of the treatment of skin cancer will indicate that a shortage has always existed, one sufficient to attract irregular practitioners into this field even before the development of scientific medicine.

Secret Formulas and Folk Medicine

Cancer pastes and escharotic preparations of various types have been a part of folk medicine and the secret formula, a part of the equipment of the non-medical "cancer specialist." Noses, ears and eyes disappeared in the process and they continue to do so, much to the chagrin of some of us who carry a major interest in this particular field. I am happy to say that education of the public is making the untoward results relatively infrequent as the procedures for adequate scientific treatment continue to increase in value.

Before the introduction of local and general anesthesia, it is quite understandable that escharotic destructive agents which did not cause immediate pain would be more popular than the actual cautery. Various chemotherapeutic agents of the destructive type continue in use down to the present time. They compete with radiation therapy and surgery and at times may be equal or superior to more conventional procedures.

We are separated by only two generations from the description of a procedure introduced by a dermatologist in which acid nitrate of mercury was used as a cauterizing agent after removal of the neoplastic lesions with a curette.[1] After an appropriate interval, the acid was neutralized with baking soda. It left a heavy eschar which separated in approximately ten days. In the opinion of some, the cure

Presented before the joint meeting of the Dermatology and Public Health sections of the 114th Annual Session of the Medical Association of Georgia, Augusta, May 5, 1968.

rate was higher than that achieved by other destructive measures.

Cautery Remains Popular

The cautery was long the favorite instrument of the surgeon even in the day when it was necessary to heat the instrument with a charcoal fire. It has retained its adherents and the actual cautery heated now by the resistent to flow of electrical current finds a place in the office of most physicians and is the instrument of choice for the removal of certain types of skin cancer by some of our current dermatologists.[2]

There is an interesting story concerning an eminent surgeon who was able to convince his patients that the cautery was not painful if it was heated to exactly the right temperature and this was determined by the color. It must be a dull cherry red. Those who become experienced in the use of bipolar electrosurgical procedures soon learn the value of the slow and the rapid cutting current and become expert in accomplishing the technical procedures at hand.

Extensive Excisions Possible

Modern surgical technique, advances in anesthesia and the control of infection have made it possible to carry out very extensive excisions with either immediate or subsequent restorative procedures which often make surgical excision the treatment of choice. This is particularly true in younger individuals and in certain regions where immediate repair can shorten the period of disability and afford a superior cosmetic result. Advances in surgical technique, particularly restorative procedures continue to attract surgeons to this important field of endeavor and those who develop skill and experience play leading roles in the care and treatment of patients with cancer of the skin and the complications and problems which develop in this field.

Use of Radiation Therapy

The introduction of radiation therapy followed the discovery of the X-ray and radium at the turn of the century. The application of these modalities to the treatment of skin cancer began before hospitals developed departments for radiological services. Before the introduction of calibrated X-ray tubes, therapy was an art indeed. The methods and the procedures in use depended largely on clinical observation of the reaction produced. The method of using multiple small doses over an extended period, which is now common practice, was not unknown at that time. Lack of knowledge regarding the inherent dangers and the potential of this agent led to many unfortunate situations. Current therapeutic procedures in the hands of experienced, well-trained therapists have produced excellent results and the method is widely used and can be the treatment of choice for skin cancer of certain types and locations. Refinement of technique and the development of special equipment continues to lead to improvement of the results obtained with roentgen therapy.

Limited Use of Radium

The use of radium for the treatment of skin cancer has never been as extensive; but in the hands of some who have acquired experience and facility with the necessary technical procedures, brilliant results have been achieved.[3] Both modalities are widely used and are considered the method of choice for some lesions by physicians who have acquired the necessary skill and knowledge to use these agents effectively.

Electrosurgical Procedure

The physician who treats ambulatory patients with skin cancer has found the electrosurgical procedure to be most expedient. The results obtained are satisfactory; hospitalization is seldom required; local anesthesia makes the procedure relatively painless and the cure rate in properly selected early cases equals that of other treatments.[4] It has become the method of choice for the majority of dermatologists and is widely used by specialists in other fields. This is particularly true when the number of lesions precludes the use of more time consuming, expensive procedures. There is still a premium on skill and judgment, and the experience of the individual physician will continue to guide his choice of treatment.

Pre- and post-operative pictures indicating the results of therapy with this procedure are not as dramatic as those which can be exhibited by the radiation therapist or the plastic surgeon who has conquered some major neoplastic disorder. It continues, nevertheless, to be the method by which the majority of skin cancers are effectively treated with the least amount of disability and loss of time for the individual patient.

'Nothing New Under the Sun'

What about new methods and new procedures? What advances are being made in the control of neoplastic diseases of the skin? There is an old saying that there is "nothing new under the sun," and this is partly true. Cryotherapy has recently been described as a new method for certain neurosurgical procedures and for transurethral destruction of prostatic tissue. This is not a new method in dermatology, but was first used for the treatment of actinic keratoses in 1904. The agent used at that time was

liquid oxygen and later carbon dioxide snow which is only half as cold. This modality is still in use along with liquid nitrogen which is colder. They produce a similar result and are adaptable to certain technical procedures. The dermatologist is familiar with the use of both agents and has used them extensively in the treatment of precancerous skin lesions, but less often for definite neoplastic disease. Recent reports indicate that its proper use can yield satisfactory results.[5]

Scientific Refinements

We are now faced with the rebirth of chemotherapeutic procedures, but this time with certain scientific refinements. Zinc chloride was one of the escharotic agents present in the secret preparations which were used in cancer paste. It has been reintroduced by Mohs[6] for the treatment of invasive types of skin cancer and recurrent lesions where other methods of treatment have failed. The procedure is combined with microscopic control by repeated examination of the tissue removed to determine whether or not all cancer cells have been eliminated. In Dr. Mohs' hands the procedure has yielded a cure rate which is higher than that of any other method used in the treatment of skin cancer, approximately 98 per cent. This approach has been adopted by others, both surgeons and dermatologists who have found it a method which is useful in difficult cases.

It is not a procedure for the inexperienced. It requires skill and knowledge in the preparation and interpretation of the material removed. It is time consuming and therefore a reasonably expensive procedure.

Treating Superficial Lesions

A still newer adventure in the control of neoplastic disease is the application of one of the new chemotherapeutic agents to topical therapy of superficial lesions. A halogenated pyrimidine 5 fluorouracil, was developed in 1957 and introduced for the treatment of leukemia in children. The adaptation of this agent, and its use in the treatment of precancerous skin lesions, was brought to the attention of the dermatologist by Dr. Dillaha in December of 1963. He had previously presented a paper[7] on this subject but his exhibit at the Academy meeting in 1963 focused the attention of many of its members on the results obtained by this procedure.

Actinic Keratoses

Extended experience with this agent has led to extensive use in the treatment and control of actinic keratoses. It is particularly efficacious in individuals who have extensive damage as a result of actinic exposure over wide areas of the skin. Lesions are present in such large numbers that they could scarcely be treated by any other method, certainly not by local treatment or excision of individual lesions, for the number present would preclude any effective control.

Experience with this form of treatment has shown that it is sometimes effective in superficial forms of basal cell skin cancer, that it can be an effective treatment for Bowen's disease[8] (intraepidermal squamous cell carcinoma). It may prove useful in the treatment of erythroplasia. It is not likely to be useful in precancerous lesions in which the number of atypical cells is small and the rate of proliferation slow.

Appreciable Variations

Regional variations and individual response to treatment are definite and appreciable. Lesions on the face respond rapidly and to the greatest degree. The ears and the post-auricular areas, and even the exposed part of the neck which has been damaged, will respond in a satisfactory manner. The barrier to the passage of the drug is apparently greater on the arms and the dorsa of the hands and the scalp, but there are surprising variations which occur in different patients and the degree of response cannot always be predicted.

Continued study of the halogenated pyrimidines and the method by which they act as antimetabolites in DNA synthesis and the role which ultraviolet radiation plays in this process is a field of continued interest and extending study. An understanding in greater depth may yield the key for some type of preventive treatment, or a method which can block or repair some of the damage which ensues following long exposure to ultraviolet light.

Choice of Treatment

A physician who is confronted with the choice of treatment by patients with precancerous and cancerous skin lesions has many factors which must be considered in order to best advise and care for the individual patient. This circle of therapeutic efforts occurs with other illnesses where all the problems involved have not been surmounted. The patient with a single lesion is often an easy problem, but this may be only the forerunner of difficulties which will follow.

We know that xeroderma pigmentosum, a rare hereditary disease leads to early development of skin cancer and there is accumulated evidence to show that it results from defective DNA repair following exposure to ultraviolet light.[9] We see few patients with this rare disorder but we recognize all degrees of variation in resistance following exposure to ultraviolet light. This extends from the Negro whose de-

fense is almost complete, to the fair Nordic types with blue eyes and reddish hair and a predisposition to damage as a result of exposure. Perhaps some mutation as a result of exposure is a contributory factor even in those who have little or no trouble unless they are unduly exposed.

Numerous Factors Involved

The clinician must consider not only the histologic type of the neoplastic lesion, but its location and size in relation to other structures, the extent and its depth, the age of the patient, his other disabilities and his life expectancy in designing a plan of treatment. In these days of traffic hazards a daily visit to the doctor's office or a hospital for treatment can at times be more hazardous than the condition for which treatment is sought. Thus, geographical and occupational factors may play a role in the choice of the most appropriate treatment.

There is no single method that can be the procedure of choice in all situations but each must relate itself to the individual and his illness. The physician with the greatest experience in the problems at hand will be the best consultant in reaching a decision regarding the choice of treatment.

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308 Ingraham Building

EMORY OFFERS NEW DEGREE: MASTER OF MEDICAL SCIENCE

A new program leading to the Master of Medical Science degree in several health specialties will be offered by Emory University beginning in September 1969. The program is designed to help combat a growing national shortage of physicians and other health personnel, according to Dr. Arthur P. Richardson, dean of Emory's medical school.

Division of Allied Health Professions

Dr. Richardson announced the creation of a new Division of Allied Health Professions which will coordinate the M.M.S. and other allied-health programs within the medical school.

Dr. Harry L. Williams, professor of pharmacology, will assume new duties as associate dean of the medical school for allied health professions, Dr. Richardson said. Appointed assistant dean was Randall W. Carter, M.S., assistant professor of radiology and physics. Mr. Carter is at present working on the plans and implementation of the new M.M.S. programs, Dean Richardson said.

Five Major Study Areas

Initially, five major study areas will be developed for the M.M.S. These include radiological health, medical technology, physical therapy, occupational therapy and anesthesiology. Other majors will be incorporated into the program as developments in the health sciences indicate the need for them, the dean said.

Emory has offered the degree Master of Radiological Health since 1966, and eight individuals have received this degree. However, graduate students majoring in radiological health will now be awarded the Master of Medical Science degree under the new program, and the M.R.H. degree will be dropped.

Qualified for Various Fields

Graduates of the M.M.S. program will qualify for several types of professional activity, Dr. Richardson said. These will include teachers of the allied-health professions; supervisors in clinical situations; clinical specialists (below the level of physician); and medical researchers. They will work as members of a health team headed by a physician.

"The demand for personnel in medicine and health-related fields has greatly exceeded the supply, and almost daily the problem of providing health care for the community becomes more critical," Dr. Richardson pointed out.

QUACKS ARE EXPOSED

Fads, Myths, Quacks—and Your Health exposes the pseudo-scientific quacks and health cultists to whom millions fall prey each year. The booklet's message is directed to the victims of odd-ball diets, off-beat treatments, or useless pills, capsules, and liquids. The pamphlet concludes with a summary of the government agencies and voluntary organizations which are fighting against frauds and through whom additional information is available. This 28-page booklet (Public Affairs Pamphlet No. 415) is available for 25 cents from the Public Affairs Committee, 381 Park Ave., New York 10016.

Early treatment and close observation resulted in a favorable outcome in the case reported.

High Dose Poisoning With Diazepam (Valium) and Survival in a Two-Year-Old Child

TERRELL B. TANNER, M.D., *and* **SAM H. MOORHEAD, M.D.,** *Hartwell*

THE CURRENT POPULARITY of diazepam (Valium) as used in the treatment of anxiety, other emotional disorders, and as a mild sedative, has led to the increasing possibility of accidental ingestion of this compound by children mimicking their parents or experimenting with medications. Diazepam is a benzodiazepine derivative, and compounds of this type were first synthesized by Sternbach in Poland in 1933. Principal interest was in its muscle relaxing, anti-strychnine action and its spinal reflex-blocking properties. In 1960 Randall et al. reported that it produced a "taming" of animal species. This "taming" effect led to additional research in 1963 by Randall, Cook and Kelleher who studied the behavior and neurophysiological actions of this medication.

Pharmacology

In animals diazepam (Valium) appears to act on parts of the limbic system, the thalamus and hypothalamus, and induces calming effects. Diazepam, unlike chlorpromazine and reserpine, has no demonstrable peripheral autonomic blocking action, nor does it produce extrapyramidal side effects; however, animals treated with diazepam do have a transient ataxia at higher doses. Diazepam was found to have transient cardiovascular depressor effects in dogs. Long term experiments in rats revealed no disturbances of endocrine function.

Oral LD 50 of diazepam is 720 mg/kg in mice and 1240 mg/kg in rats. Intraperitoneal administration of 400 mg/kg to a monkey resulted in death on the sixth day.

Centrally Acting Muscle Relaxant

It has anticonvulsive effects, including blockade of convulsions induced by strychnine, pentylenetetrazol and ECT. Diazepam has been advocated as a centrally acting muscle relaxant, found to be capable of abolishing spastic rigidity in decerebrate cats. The EEG patterns resemble those found without drugs. Patients exhibit slurred speech, ataxia and incoordination on usual dosage, and although they are easily aroused, they go back to sleep when undisturbed.

The drug is slowly excreted in the urine with high plasma levels still evident 24 hours later and measurable amounts present 48 hours after a single large dose is given. Peak level is reached in about eight hours. Twelve per cent of the dose is accounted for in 96 hours if collected in the urine and measured. After the drug is discontinued, plasma levels decline slowly over several days.

Dosage

Diazepam is available as 2, 5 and 10 mgs. tablets. The dosage is considered dependent upon the severity of symptoms to be treated and ranges from 2 mgs. per day in mild anxiety state to 40 mgs. per day for the treatment of alcoholism or severe dystonias associated with cerebral palsy or athetosis.

Toxicity of this compound appears to be relatively low, although somewhat greater than that of

meprobamate. Driving an automobile or performing similar tasks under the influence of these medications is not recommended and may be dangerous. Furthermore their combination with other agents that may produce additive or supra-additive effects should be approached with caution, for example, alcohol, barbiturates, phenothiazines and MAO inhibitors.

The most common side effects are signs and symptoms of central nervous system depression including drowsiness and lethargy. Elderly patients appear to be especially sensitive to these drugs and tolerance to alcohol is increased by their concurrent use. Physical dependence on diazepam appears to resemble that seen with the barbiturates and meprobamate. In one study in which a dose ten times the usual therapeutic dose was given for several months and abruptly switched to placebo, patients experienced withdrawal symptoms a few days later. Eleven patients were studied in this situation and two of the patients had seizures about a week after discontinuance.

Poisoning Is Rare

Poisoning with these drugs appears to be relatively rare. Zbinden and co-workers reviewed 22 attempts of suicide with a diazepam congener chlordiazepoxide by patients who ingested from 200 to 250 mgs. of the drug at one time (about 6 to 8 times therapeutic dose). Although drowsy and sedated, they were arousable and able to talk, eat and drink. Respiration, blood pressure and pulse were somewhat depressed, but not to the extent seen in severe barbiturate intoxication.

Of course the toxic and poisoning rate would be higher per mg. ingested and the experience of the medical profession with diazepam ingestion in children so far reported by Goodman and Gillman has been approximately 100 mgs. ingestion in a child weighing 40 pounds. A case is now reviewed in which a documented higher dose was taken and evidence that a higher dose can be tolerated by a smaller child is given and its management in this case is put forth.

Case History

On May 9, 1968 at 8:45 p.m. a two-year-old child was brought to the emergency room at Hart County Hospital, limp and somnolent after having been found in the automobile where she had been left to wait for her mother. She was holding an empty bottle which had contained a new prescription of 30 diazepam (Valium) 10 mgs. tablets and had taken them all by mouth. Gastric lavage was begun immediately with plain tap water. The time interval between the ingestion and lavage is estimated at 25 to 30 minutes. The lavage was continued for 30 minutes with some material identifiable in the return as probably being particles of medications.

On first seeing the child she was arousable and would smile but made no attempt to talk. Her communication was limited to nodding or shaking her head for "yes" and "no" answers. Within approximately 10 minutes she was no longer arousable and within 20 minutes painful stimuli did not cause any response. All this time the lavage was being continued. She was at this time referred to an adjoining hospital for specialist care by a pediatrician.

The mother is 29 and the father 39 years of age. She was carried to term. Mother is gravida 5 and para 4, abortus 1 and delivery O. K. Child's shots up to date. Illnesses: The child was treated occasionally for asthma. Siblings are nine, six and five. Physical examination: Child weighs 27 pounds. On admission showed a lethargic, young, white female with decreased reflexes in all areas who would lie quietly and let you draw blood from her leg or do other manipulatory procedures, without crying.

An infusion was started on this child to keep the hydration constant and the drug representative was called in Greenville, South Carolina who gave additional information regarding reports of an overdosage with this drug.

Vital Signs Watched

A close record of the vital signs was kept on the child. The respiration remained constant. The blood pressure remained stable about 100/80. The pulse remained constant within normal limits from the beginning to the end of the hospitalization.

Laboratory Data

Lab data on the child reveals a 48 hour trace on the cephalin flocculation and a 34 hematocrit; 12,-760 white cells. 11.4 hemaglobin with 21 bands, 6 to 7 lymphs, 8 monos., 2 eosins. BUN was 18. Bilirubin was .3 total, .1 direct and .2 indirect. SGOT was 38 units with normal 8 to 40. Thymol turbidity 5.9 units with normal 0 to 4. Urinalysis, repeat straw color, 1.008 specific gravity, 8 reaction. Rare red cells and 1 to 2 white cells. Albumin, sugar and acetone were negative. Serum iron was found to be 20 mgs. per cent.

This child had a smooth hospital course and the IV was continued through the second day. The next morning the child could walk around weakly and she was discharged the morning of the third hospital day. Final diagnosis: Valium overdosage.

Discussion

A two-year-old 27-pound female ingested 300 mgs. diazepam (Valium) by accidental poisoning.

Gastric lavage was begun within 30 minutes, and continued for 30 minutes. Within an additional 30 minutes hydration and close observation were begun. No other medications were given. The child survived apparently without sequelae.

Hartwell Plaza

80 Years Ago

TO THE MEDICAL ASSOCIATION OF GEORGIA

Mr. President and Gentlemen: It was my design to be with you on this occasion, but circumstances so conspired as to preclude the possibility. Hoping that your honorable and appreciative body might have a pleasant and profitable meeting, and being a member from the Second Congressional District on the Committee on Gynecology, not being able to report anything more important, I beg to offer a few observations in the use of *antipyrine* in gynecological practice.

If the following should be of service to your deliberations, then my purpose will have been accomplished.

Case 1.—Mrs. B., æt. about thirty years. A delicate woman, of nervous temperament, having borne two children, when I became acquainted with the case, I found that the periodical menstrual periods were attended with severe headache, nervous prostration, muscular spasm, nausea and retching. For some time I endeavored to alleviate, or palliate, her sufferings. Used the regular prescribed methods with partial relief, yet each returning period the same distressing symptoms would return. Other physicians were called in and consulted, yet without any appreciable benefit. Having used antipyrine in other nervous and muscular troubles, I concluded to use it. My first dose proved of advantage in relieving her distressed condition. She was enabled to get some quiet sleep. Repetition of from four to six hours completed her recovery.

I have, from time to time, on these occasions, had to resort to this remedy in her case, with marked benefit to nervous excitement from which she suffered. I have found it, however, not infallible in her case, as nausea would supervene; yet the other nervous troubles could be controlled.

Case 2.—Mrs. W., æt. about twenty-six years; nervo-lymphatic. Was confined. She was delivered favorably; progressed favorably until the fifth day.

I was called to see her. Found her with temperature 105; pulse 120; severe pain over the abdomen; mammal tense, hard, painful. She was in a semi-delirious state.

Fearing an aggravated puerperal state, as well as abscess of mammary gland, I resolved to try antipyrine. I gave her, immediately, twenty grains; returned in two hours; found her with scarcely any pain; temperature 102; pulse 100; perspiring profusely, so much so that her clothing, as well as bedding, were saturated; did not give another dose; recovered.

However, the secretion of milk was never established. The infant was forced to be fed artificially.

Case 3.—Aet. about twenty-eight years; nervo-sanguine; a sufferer for years. Treated her for intra-cervico metritis, uveralgia, splenalgia, dyspepsia, etc. Exhausted my fund of knowledge; called others in, yet the same old song. I resolved to try antipyrin. It proved of benefit, and so much so, that, whereas, it was no unusual thing to treat her for a week or ten days in a month. I have had no occasion to treat her in four months.

Case 4.—Aet. about forty years; brunette; eight months enciente. Called to see her. Suffering headache, backache; threatened miscarriage; temperature 104; pulse 100. Gave her twenty grains of antipyrin; fever subsided; calmed nervous excitement; produced rest and quietude, and bids fair now to reach maturity without any bad symptoms.

I have used the remedy in various cases of dysmenorrhœa, amenorrhœa, with good apparent results.

If these few observations can be of service, either to provoke discussion or criticism, my purpose will be subserved.

Yours respectfully,

T. S. Dekle, M.D.

Thomasville, Ga., April 16, 1888.

From the Transactions of the Medical Association of Georgia, Thirty-Ninth Annual Session, 1888, Macon, Georgia

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Special Article

This paper aims for a better understanding of this much discussed problem.

Present Status of Workmen's Compensation Fees

TOM S. HOWELL, JR., M.D.,* *Atlanta*

During the past few years physicians in Georgia have expressed increased dissatisfaction with the Workmen's Compensation Fee Schedule. Realizing this dissatisfaction, the Chairman of the State Board of Workmen's Compensation met with the Medical Association of Georgia on two occasions. These meetings were productive and established an atmosphere of co-operation between the Medical Association and the Workmen's Compensation Board. Dr. Henry Jenning's Committee of "Medical Review and Negotiation" was asked to assist in working toward agreements on "usual and customary charges."

Objection to Fee Schedule

Much legitimate objection has been raised by physicians to a fee schedule of any type, but there is opposition to completely abolishing this regulatory mechanism. Since medical payments are fixed at a maximum limit of $5,000, both labor and industry are reluctant to give the physician a "blank check." The vast majority of physicians' charges are well within acceptable limits; however, the occasional grossly excessive charge is utilized as an example against allowing complete freedom of billing. At present, the Workmen's Compensation Board is charged with the administration of the Compensation Act and is unable to grant "usual and customary" charges without appropriate studies.

First Steps Taken

On May 22, 1968 a letter from the State Board of Workmen's Compensation was submitted to "all insurance companies and self-insurers." This initial effort was aimed at increasing the basic charges. For example, the charge for the initial office visit would be $10 instead of $5; routine office visits would cost $6 instead of $4; and the charge for a hospital visit would be raised from $5 to $7.

This letter further stated that the "Board is currently studying the remainder of the fee schedule in an attempt to up-date the entire schedule. Included is a complete study of the procedures used in determining the amount of charges allowable and the procedures for reporting by the physicians." The basic idea was an attempt to utilize the California Fee Schedule with an appropriate "factor." This schedule is currently used by many physicians in determining their charges and the Compensation Board felt that such an approach was practical.

Two-Year Evaluation Period

The actual plan was to allow the individual physician to bill his customary charges (his report to include the specific procedure number from the California Code); however, fees would have been subject to regulation. During a two-year interval under such a system, the "usual and customary" fees would have been established and information obtained for the Compensation Board to evaluate the effect on insurance rates.

Revisions Have Been Halted

When the attempt at up-grading the Fee Schedule became known, insurance companies immediately asked for evaluations regarding an increase in rates. The National Council on Compensation Insurance has estimated that these initial changes (previously described) will increase insurance premiums six per cent or approximately a total of $2 million per year for the State of Georgia. This estimate was not greeted with enthusiasm and at present all change has been halted pending further estimates of the proposed increase of actual procedures utilizing the California Code.

Committees from the Medical Association of Georgia will continue to work with the Workmen's

* *Dr. Howell is Chairman, Occupational Health Committee, Medical Association of Georgia.*

Compensation Board toward an acceptable resolution of the problem.

Suite 403-404
663 West Peachtree St., N.E.

Addendum: Since this article was submitted for publication, the Workmen's Compensation Board has approved new forms for billing, utilizing the "California Code" as a basis for increasing present charges. A copy of the Board's recommendations has been mailed to all members of the Medical Association of Georgia. This recent change, although a step toward "usual and customary" charges, has actually created additional problems for the physician.

GP'S HOLD 20TH ANNUAL SCIENTIFIC ASSEMBLY

The Georgia Academy of General Practice, meeting in Savannah for the first time in many years, drew a large and representative crowd to its two-day 20th Annual Session on November 15-16.

Gathering at the new DeSoto Hilton Hotel, Family Physicians from across Georgia heard a series of papers at its Scientific Assembly in addition to installing Academy officers for the 1968-69 year.

The program faculty included three out-of-state and three in-state speakers who lectured on diabetes mellitus, injuries of the hand, the treatment of alcoholism, diagnosis of heart disease, sex and adolescence, and treatment of infective cases of tuberculosis. Question and answer sessions provided a lively change of pace at the conclusion of each day's program.

Irving D. Hellenga Installed as President

Irving D. Hellenga, M.D., of Toccoa was installed as President of the Georgia Academy for the 1968-69 year.

The scientific portion of the meeting was made possible through grants from the following pharmaceutical houses: A. H. Robins Company, Bristol Laboratories, Eli Lilly and Company, E. R. Squibb and Sons. Mead Johnson Laboratories, Merck Sharp and Dohme, Parke-Davis, Wyeth Laboratories and Pfizer Laboratories.

SOCIETY OFFERS HELP FOR AUTISTIC CHILDREN

Pediatricians, family physicians, psychiatrists and others having knowledge of children with severe emotional illnesses are invited to refer their parents to the Georgia Society for Autistic Children, Inc.

Provides Care and Treatment

Formed in 1967 by parents of autistic children, this group is a voluntary organization, dedicated, through research, training, treatment and care, to the welfare of children with infantile autism, autistic-like behavior, childhood schizophrenia or other profound behavioral disorders. One of the most useful functions that this organization has undertaken is an information service where parents and others can find out about hospitals, schools, treatment facilities and many other aspects of existing provisions for mentally handicapped children.

State-Sponsored Project

The Georgia Society for Autistic Children has been instrumental in obtaining, on a pilot project basis, The DeKalb Center for Children With Behavioral Disorders (Autism). This State-sponsored project, operated by the DeKalb County School System, hopefully will demonstrate that many of these children can be trained, in proper special education facilities, in order to prevent perhaps a lifetime of confinement to a mental institution. The Society also conducts parent study groups from time to time in an effort to assist parents in working with their children.

Non-Profit Organization

The Georgia Society for Autistic Children is a non-profit Georgia corporation. Its president is Mr. S. Clarence Griffith, Jr., Administrator of Ponce de Leon Infirmary. The vice president is Mr. Charles E. Shell, Counselor in Special Education, DeKalb County Schools. For additional information write to Post Office Box 6011, Station "H," Atlanta, Georgia 30308, or telephone 634-7482 or 233-0962.

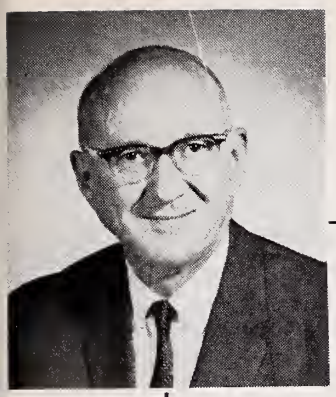
CALL FOR SCIENTIFIC EXHIBITS

115TH ANNUAL SESSION OF THE MEDICAL ASSOCIATION OF GEORGIA

Savannah, Georgia, May 4-7, 1969

For Information and Applications, Write:

John McClure, Jr., M.D., Chairman, MAG Scientific Exhibits Committee
938 Peachtree Street, N.E. • Atlanta, Georgia 30309



MAG FOUNDATION

WELL CONCEIVED BUT POORLY ACCEPTED has been the Medical Association of Georgia Foundation, Inc. Much time was spent, and intelligent thought given to the feasibility of its inception. Those leaders in MAG, whom you have chosen, decided in 1967 after long and considered deliberation that the Foundation would be advantageous to all, particularly those interested in a corporation designed to foster and promote every facet of MAG obligations which go beyond operational procedures.

Basic necessities for the continued existence of the MAG structure have been status quo. But we are in a world of changing times, and as an educated and supposedly thinking segment of our civilization, we must take steps to improve our fundamental organization. Some related phases of basics include public relations. Our Foundation can magnify many aspects of our public relations, including our image to the public and our normal obligation to our fellow man involving charity, education, and research.

Ignored by Members

To those few who read this letter please let me ask you to encourage all of your contacts to become aware of the MAG Foundation. It is your Foundation, non-profit, and tax deductible. It has regrettably gotten off to a slow start, and, I think, possibly because of lack of attention by individual members to this great potential of helping our fellow man.

It will not take a huge effort to get your Foundation off the ground. But it will take at least a small endeavor on the part of every member. While this Foundation is new in Georgia, it is not untried in other States. One State Medical Society Foundation received more than $186,000 in membership contributions the first two years. Another State Fund in one year committed $300,000 of its funds to student loans—do you know how much the State of Georgia Medical Education Committee has available for potential students? You must be aware that the lack of medical facilities is a cause relating to the shortage of prospective M.D.'s. We need to be in position to help financially our medical schools in all phases—via MAG Foundation!

Sound Idea; Honorable Objectives

The idea of the MAG Foundation is sound. The objectives are genuine and

honorable: (1) To engage in and carry out scientific research, charitable, educational and scientific activities and projects; (2) to lend financial assistance to needy members of the medical profession and their families; (3) to assist medical students and paramedical students in the pursuit of their education; (4) to administer governmental programs and grants; (5) to accept and hold in trust or otherwise as assets of the corporation consistent with its other charitable purposes. Until the present time it has been the attitude of your Executive Committee, Council, and House of Delegates that MAG take an interest in aiding to the fullest extent all government health programs put into law, and we have done so, even to the extent of offering our facilities both executive and physical. (Your MAG has the know-how as proven by the most economical military medicare facility in the nation.)

Funds May Be Ear-Marked

This is a most propitious time for tax deductible donations. We need to go ahead with our Foundation. If doctors do not lead the way, others will not follow. It does not take a large donation from one individual. You should become familiar with the benefits of the Foundation and let others know. Not only M.D. individuals but anyone may contribute and donations can be designated for a specific or general fund. Medical Societies, industry or individuals, may earmark funds for medical, educational, scientific or charitable purposes. (Many involve lectureships, awards, specific research, or medical charities.)

More understanding and dissemination of information about the Foundation is needed. Let your local bankers know about our Foundation; let wealthy people know about it; many industries should be interested. Brochures are available at MAG headquarters.

If it doesn't strain you too much make a small contribution, the MAG Foundation, Inc. can reap the MAG more benefits than you can imagine. Admittedly, I have made some contributions to foreign missions and personal indulgences which could have been spent otherwise, but I believe charity and self-preservation should begin at home.

God bless you and Merry Christmas,

Charles R. Andrews Jr. M.D.

Charles R. Andrews, Jr.
President, Medical Association of Georgia

If you think the pink pill for U.R.I. symptoms is built for speed and endurance you're on the right track.

Here is a tablet that begins to relieve symptoms of upper respiratory infection quickly—a tablet that works for hours to make it easy for your patient to enjoy continuous relief.
Novahistine Singlet combines effective dosage of an antipyretic-analgesic with a vasoconstrictor-antihistamine formulation to relieve not only the congestion, but also the fever and the aches and pains that almost always accompany upper respiratory infections.

A total daily dosage of 3 or 4 tablets will normally provide the continuous relief your patient expects. Use with caution in patients with severe hypertension, diabetes mellitus, hyperthyroidism or urinary retention. Caution ambulatory patients that drowsiness may result.

PITMAN-MOORE Division of The Dow Chemical Company, Indianapolis, Indiana.

Novahistine® Singlet decongestant-analgesic

(Each tablet contains: phenylephrine hydrochloride, 40 mg.; chlorpheniramine maleate, 8 mg.; acetaminophen, 500 mg.)

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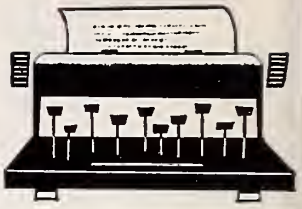
EDITORIALS



Bring Us Together Again

"With malice toward none, with charity for all; with firmness in the right, as God gives us to see the right, let us strive on to finish the work we are in; to bind up the nation's wounds; to care for him who shall have borne the battle, and for his widow and his orphan—to do all which may achieve and cherish a just and lasting peace among ourselves and with all nations."

Abraham Lincoln
Second Inaugural Address
March 4, 1865

WITH THE CLOSE OF THE War Between the States, the great national purpose as seen by Lincoln was to BRING US TOGETHER AGAIN. We had passed our greatest crisis. What lay ahead was a period of uncertainty; a period during which we would "bind up the nation's wounds" and seek again to become one people.

Scholars have long speculated on the course of events had Lincoln lived. The bitter tragedy of the post war years remains, however, that an assassin's bullet altered the course of history and Lincoln's commitment to make us one people again became a long and torturous ordeal in the hands of less dedicated men.

We come now to the year 1969, and once again the overriding objective of the nation must be to BRING US TOGETHER AGAIN. Such is the stated purpose of the next Administration. President-Elect Nixon, in his victory statement following the November general election, recalled this legend from a placard held by a little girl during a whistle-stop campaign in a small Ohio town: BRING US TOGETHER AGAIN.

The problems that beset the nation are grave ones. The problems themselves are real enough. However, when compounded by those who seek profit through division; by those who would fan the fires of economic and social differences for reasons alien to the national purpose, the spectre of internal collapse becomes all the more possible, and the need for unity all the more necessary.

For better or for worse, we are a United States, and for reasons best appreciated by each individual in this country, we must remain a united people.

LET US BRING OURSELVES TOGETHER AGAIN.

Is There a Doctor in the House?

BEGINNING WITH THE 1969 regular session of the Georgia General Assembly, the Medical Association of Georgia will set up and maintain a dispensary at the State Capitol to serve the members of the House and Senate throughout their 40-odd days in Atlanta.

Volunteer physicians from across the State are being recruited to serve as

"Doctor-for-the-Day" at the Capitol each day that the House and Senate are in session. The DOD idea has been discussed with and has the approval of, the Speaker of the House of Representatives, George L. Smith, III, and the presiding officer of the Senate, Lt. Governor George T. Smith.

At the present time there is no physician to the General Assembly, nor in the memory of anyone with whom we have talked, has there ever been one. In the past when emergencies have arisen, help has had to be summoned from a distance with the ever present risk that it might not arrive in time.

Treatment for Minor Problems

The basic concept of the "Doctor-for-the-Day" project, however, is not emergency treatment of a "life or death" nature, although that contingency will be covered. Rather it will be to furnish day-to-day treatment of minor problems in the interest of helping members of the Legislature perform their important duties with a minimum loss of time. An important aspect also is to help create a peace-of-mind atmosphere in the General Assembly that comes with the knowledge that medical help is close at hand.

In addition to having a physician on hand each day, present plans call for a volunteer nurse to assist the doctor at the Capitol. Nurses will be drawn from the membership of the Georgia State Nurses Association on a volunteer basis as arranged through their Association.

Provisions for Emergencies

A special roster of Atlanta area internists and surgeons to whom serious emergencies may be referred will also be an important feature of this project. And, of course, the legislator's personal "hometown" physician will be advised of any treatment given by the Doctor-for-the-Day.

Thus far, the project has met with enthusiastic acceptance on the part of all who know of it. It was conceived in a spirit of public service and it should be made clear that it will not serve as a "front" for an inside lobby.

Nonetheless it must be clear that the good will to accrue to the profession as the natural result of this type of public service should be considerable.

Recipe for a Merry Christmas of Long Ago

INGREDIENTS: A GRANDMOTHER and grandfather, children, in-laws and grandchildren, a small town, a rambling house on a farm, horses, mules, bird dogs, chickens, cats, hogs and cows.

Grandmother Needs Patience

Now the grandmother should be blessed with good health and a love for food. She should be a glutton for hard work through the years, but especially just before Christmas. She must love people and children, especially those of her kin who descend on her at this time of year. She must be slow to anger, especially with grandchildren who trample cookies and jelly into her rugs, who bring in dirt and mud on their shoes, and who never close a door, regardless of the temperature. She must not worry too much when they poke the fire, causing the sparks to fly.

She must bake the cakes in advance and acquire presents for all the clan. Popcorn and marshmallows should be in the pantry. She must make sure that

Susie Ann and Aunt Rose will help her during this time of cooking, cleaning, and washing dishes and diapers.

Grandfather Must Have Stamina

Now the grandfather must be of great stamina also; he will have to go into the swamp and cut a Christmas tree. He knows, too, that when the sons and sons-in-law hit the house, the first thing they will want to do is to hunt quail or shoot doves. That means that he must arrange to borrow extra bird dogs, and learn where the doves are congregating.

The first thing the grandchildren want to do is ride something—mule, horse or bull yearling—and they will want to ride in a one-horse wagon and drive a mule. They will want to help milk the cows and gather the eggs. Grandfather must divide his time between the hunters and the grandchildren, and the latter usually win out.

Grandchildren Help Milk Cows . . .

Milking time is a great joy for the grandchildren, especially those from the city. He lets them carry the buckets and some water. By the time he is ready, some cats have already appeared—especially if there is a mama cat and kittens. Granddaddy squirts milk into the cat's mouth some 10 feet away; then the grandchildren try the same stunt, and there is much carrying on "Let me try, let me try." If the grandsons were old enough and the women-folk were in the house, he would let them catch a bull yearling and try to ride him, or try to throw him and tie his feet together, but about all they would get out of this would be bruises and laughter.

. . . And Gather the Eggs

The youngest love to find hens' nests and gather the eggs. Although, they do this four or five times a day, there always seem to be eggs in the nest. One of the daughters-in-law remarked one time that those were the "layingest chickens she'd ever seen."

On Christmas Eve the men must bring in some quail and doves, maybe a rabbit or two, and perhaps a squirrel. The grandchildren must be introduced to the subtle art of plucking feathers and skinning an animal, all of which is done down by the syrup mill some 75 yards away from the house.

When this is finished, the grandchildren are sent in to wash up for supper, but the oldest is always asked to bring back a good sized pitcher of water and a glass or two—theoretically to wash down the table where the game has been cleaned.

Santa Claus Waits

After a bountiful meal, the presents are placed under the lighted tree and the stockings are hung. The men in their hunting clothes are tired—their feats of great marksmanship and their excuses have been told and retold. The servants are home, grandmother is tired, the mothers are weary and the grandchildren want to go to bed, but Santa Claus is coming and they are excited. Suddenly, Grandfather cocks his ear and vows he hears a noise on the porch. He and all the children go out to investigate. Grandfather declares that he saw Santa peeping through the window and run down into the field. That's all they need; they go to bed.

The next morning is bedlam, of course. The stockings are emptied and packed again many times—cap pistols pop, and vehicles run all over the place.

And then after breakfast the presents under the big tree are passed out by the grandchildren. The ladies open their presents and say "Ooh! Aah!, darling!,

Thank you, thank you so much." The men all say, "Just what I needed, thank you."

Time to Leave

After the excitement has settled down, everyone except the children—God bless them—commence thinking about the long trek home. The fathers worry especially about how in the world they are going to pack everything in the car.

Grandmother and Grandfather are tired, but, as the cars drive away and good-byes have been said and evening is coming on, Grandmother and Grandfather walk back into a cluttered, empty home. Darkness has just set in—the fire in the fireplace is low, spewing up a flame now and then. The quietness overwhelms them. They sit and gaze at the flickering embers. Grandfather gets up and puts another lightwood knot on the fire and looks over at Grandmother; she is silently weeping—he looks back at the fire as it flares, and his eyes cloud a little bit too. He goes over to the divan and sits beside her. He takes one of her hands, puts it on his knee and covers it with his big gnarled hand. They watch in silence as the fire flickers to the end of this Christmas Day, and as they sit, they think back over the Christmases of 40 or 50 or 60 years ago and are content.

J. G. McDaniel, M.D.

HIGHLIGHTS OF EXECUTIVE COMMITTEE OF COUNCIL MEETING, OCTOBER 13, 1968–ATLANTA

This summary is being published so that you may be advised of the actions of the Executive Committee between meetings of Council. It covers only major actions and is not intended as a detailed report in lieu of meeting minutes.

SUIT TO ENJOIN HEALTH DEPARTMENT DIRECTORS—Mr. W. B. Spann, MAG legal counsel, reviewed the decision of Judge Sam McKenzie in the case to enjoin the State Health Department Director from payment for drugs prescribed by osteopaths under the Title XIX program. The Committee voted to approve filing notice of intention to appeal the decision to the Supreme Court of Georgia and also authorized a continuation of negotiations with the Osteopaths and the Board of Medical Examiners regarding possible legislation to establish a composite board of examiners for medicine and osteopathy.

MAG ROSTER PUBLICATION—September Council directed staff to study the matter of publishing a mid-year MAG roster rather than a January roster. Following a report on this matter by the Executive Secretary, the Committee voted not to publish a roster in January 1969, but to publish it as soon as possible following confirmation of committee appointments to be made at the June, 1969, meeting of Council.

CONFIDENTIAL MEDICAL REPORTS FOR BIRTH AND FETAL DEATH CERTIFICATES—The Committee received a report from Dr. Eugene Griffin, Chairman of the MAG Committee on Maternal and Infant Welfare, explaining a form prepared by the Committee for use in obtaining confidential information related to birth certificates and fetal death certificates. The Executive Committee approved use of the form and voted to request the Board of Health to incorporate this form as a part (detachable and confidential) of birth and fetal death certificates.

NURSING PRACTICE STANDARDS—The Committee approved a "Joint Position Statement on Nursing Practice" submitted by the Georgia State Nursing Association, and the MAG Committee on Nursing Liaison. Also approved was a "Joint Statement of Policy on Intravenous Administration of Fluids, Blood and Its Derivatives, and Drugs by Registered Nurses Licensed to Practice in the State of Georgia."

OTHER MATTERS WERE: Received for information reports on the HEW Cost of Care Conference, MAG-Board of Medical Examiners Liaison Committee, and MAG Building construction progress; approved in principle a publicity campaign on smoking as a probable cause of cancer, and on Pap smears, and requested specific recommendations for this campaign from the Cancer Committee to the Council; approved the idea of presentation of AMA Viet Nam awards by County Medical Societies; approved $150 for special Annual Session mailing to be taken from Executive Committee discretionary fund.

Second Annual

COMMITTEE CONCLAVE

July 26-27, 1969

Marriott Motor Hotel **Atlanta, Ga.**

THE GEORGIA REGIONAL MEDICAL PROGRAM:
Past, Present, Future

(Following is a recap of how the Georgia Regional Medical Program began, what has been accomplished during the planning stage, and what is being done now that the Program is operational.)

In October of 1965 President Johnson signed Public Law 89-239 creating the Regional Medical Programs for Heart Disease, Cancer, Stroke and related diseases. To carry out the purposes of the law, a new Division of Regional Medical Programs was formed within the National Institutes of Health—its aim to make new medical knowledge and technics available to all. (The DRMP has since been transferred to the health services and mental health administration of the U.S. Department of Health, Education and Welfare.)

Planning Stage

Today, there are 54 regional medical programs underway across the nation. Planning was begun in this State as a region shortly after the enabling law was passed. Under the leadership of George Alexander, M.D., then president of the Medical Association of Georgia, the Board of Medical Education of MAG; Arthur P. Richardson, M.D., Dean of Emory University School of Medicine and his associates; and Harry B. O'Rear, M.D., President of the Medical College of Georgia and his associates, discussions of the legislation and its effect on Georgia were begun.

These discussions were enlarged in January of 1966 to include representatives of the Georgia Heart Association, Georgia Division of the American Cancer Society, Georgia Hospital Association, Georgia Department of Public Health, Georgia State Medical Association, Georgia Dental Association, Georgia Pharmaceutical Association, Georgia Division of Vocational Rehabilitation, Georgia State Nurses Association, and Georgia State League for Nursing. Plans were begun at this time to organize a Regional Advisory Group as required by the law.

Purpose of Programs

The purpose of Public Law 89-239 under which this program functions can best be expressed in the following quote from the law itself:

"(A) To encourage and assist in the establishment of Regional Cooperative Arrangements among medical schools, research institutions, and hospitals for research and training including continuing education and for related demonstrations of patient care in the fields of heart disease, cancer, stroke, and related diseases;

"(B) to afford to the medical profession and the medical institutions of the nation, through such cooperative arrangements, the opportunity of making available to their patients the latest advances in the diagnosis and treatment of these diseases; and

"(C) by these means to improve generally the health manpower and facilities available to the nation and to accomplish these ends without interfering with the patterns, or the methods of financing, of patient care or professional practice, or the administration of hospitals, and in cooperation with the practicing physicians, medical center officials, hospital administrators, and representatives from appropriate voluntary health agencies."

MAG Becomes Agent

In the Summer of 1966, the Regional Advisory Group was formed and a Steering Committee was designated consisting of: J. Willis Hurst, M.D., Chairman; Robert L. Brown, M.D.; J. Gordon Barrow, M.D.; Raymond P. Ahlquist, Ph.D.; and Louis L. Battey, M.D. This group was requested to draft a proposed planning grant application to be submitted in September, 1966. At that time the Medical Association of Georgia offered and was accepted as the applicant or fiscal agent for the Georgia Regional Medical Program. J. W. Chambers, M.D. was designated Program Coordinator and ex officio member of the Steering Committee. Later, when Dr. Barrow became the full-time Program Director, he became an ex officio member of the Steering Committee and J. B. Ellison, M.D., of the Georgia State Medical Association was elected a member of the Committee.

Application Approved

The Planning Grant Application was approved by the National Institutes of Health in December of 1966 for a twelve-month period, with the assurance that it would be extended through June 30, 1969. A total of approximately $600,000 will be awarded for planning during this 2½ year period.

Activities were briefly delayed while suitable full-time staff were being recruited, but by June, 1967, J. Gordon Barrow, M.D., who serves as Program Director and Robert R. Smith, M.D., who serves as Associate Director, had begun to assemble the nucleus of a staff which today numbers 31 professionally qualified people.

Organizational Structure

The organizational structure of the GRMP is as follows: The Medical Association of Georgia as applicant and the Program Coordinator, together with the permanent staff, serve as agents for the organizations comprising the Regional Advisory Group and carry out the program as developed by the Advisory Group in the name of the Georgia Regional Medical Program. The Steering Committee is the executive body with day-to-day responsibility for the supervision of both the planning and the operational activities and final review of all projects before they are submitted to the Advisory Group for approval. The Committee also acts as liaison between the staff and the Advisory Group. The Advisory Group meets twice yearly with its Steering Committee, the Program Coordinator and

the Program Director, while the Steering Committee meets at least twice between these meetings and has the authority to act on any matter requiring consideration between meetings.

Advisory Group

The Advisory Group is composed of 110 members and alternates representing 23 organizations and institutions. Broadly representative of the geographic area and of the health interests of the region, the membership includes: practicing physicians, nurses, dentists, pharmacists, medical center officials, hospital administrators, representatives of appropriate medical societies, other health professions, volunteer health agencies, and members of the public familiar with the need for services provided under the Program.

The purpose of the Group is to advise and assist in the planning of the regional cooperative arrangements established under the program. Members are nominated by their respective organizations and their appointments confirmed at the annual meeting of the RAG held each September. Current Chairman of the Group is Arthur P. Richardson, M.D., Dean of Emory University School of Medicine. Vice Chairman is J. Rhodes Haverty, M.D., Secretary of the Medical Association of Georgia; and Secretary is Raymond P. Ahlquist, Ph.D., Associate Dean of the Medical College of Georgia.

Hospital Participation

GRMP initiated its planning by inviting each hospital in the State to appoint a local advisory group to serve as liaison between the Regional Program and the local community. It is felt that involving these groups in the planning and coordination of program activities at the local level and designating the local hospital as the central focal point through which the objectives of the program will be carried out, will serve to stimulate a new interest in continuing education and research, in recognizing community health problems, and in measuring the effectiveness of current approaches to disease problems.

Unique Approach

To date, out of 176 hospitals in the region, 125 have appointed local advisory groups. These represent 90 per cent of the general and limited services hospital beds in the region. Nearly all of the hospitals have followed the minimum recommended membership of a local group: a physician, a hospital administrator, a nurse and at least one interested member of the public. This unique approach by GRMP to affiliate local direction with the overall program of health planning and operation has gained national attention and is being observed for its success.

The chairmen of these local groups met in Atlanta on June 4, 1967, for orientation to their role in GRMP and to make suggestions regarding some of the local needs in the areas of heart disease, cancer and stroke. They met again on March 24, 1968, for a review of the Program's Operational Grant Request and a summary of the progress to date on both the national and regional levels. Subsequent meetings will be held at least once annually.

In communities having more than one hospital, the local groups of all the hospitals have met to consider jointly the needs of the community and to combine proposals. If a metropolitan planning agency exists in a community, these plans must be reviewed and approved by such agency before acceptance by GRMP.

Continuous Interchange of Ideas

The organizational structure of GRMP is designed so that the local advisory groups relate directly to the Regional Advisory Group and subsequently to the Steering Committee and central coordinating staff. They relate to all of the agencies and institutions in their area and to the task forces which are described below. This organizational framework provides a channel for continuous interchange of ideas and recommendations. Local groups also participate in the area planning of the Comprehensive Health Planning Council of the State of Georgia.

Task Forces

In June, 1967, the Steering Committee directed appointment of a group of specially qualified consultants to assist in planning the operational phase of the program. These task forces were organized in three broad categories: (1) Disease Oriented—to study needs in specific disease areas; (2) Coordinating—to project plans to meet these needs; and (3) Evaluation—to build in proper evaluation of each phase of the operational plan.

The disease oriented task forces were charged to document the extent of the problems caused by the diseases in question and what was presently being done; then to make recommendations to the appropriate coordinating task force as to the proper role of the GRMP in meeting these needs.

Operating Plan Outlined

Suggestions from the Regional Advisory Group and from local advisory groups were received and considered. Voluntary health agencies, organizations and institutions concerned with health care were contacted, their current activities in each disease area explored and their suggestions for needed improvement and possible cooperative endeavors obtained. The task forces then worked with the Steering Committee to develop a broad general plan for the operational phase of the program.

On January 21, 1968, the Steering Committee and Task Force Chairmen met to approve and/or modify project proposals to be included in the Operational Grant Application.

Priorities for action were recommended which were then submitted to the Regional Advisory Group for final approval on February 25, 1968.

The grant proposal, which had a total overall budget for the first twelve-month period of slightly less than $2 million, was submitted on March 1, 1968, through the Medical Association of Georgia to the Division of Regional Medical Programs in Washington, for consideration by the National Advisory Council.

Operational Funds Awarded

In July, GRMP was notified that $1,416,777 in operational funds had been granted by the U.S.P.H.S. for the first of a three-year program placing Georgia among the first 25 regions to move from planning to

operational status. The funds will underwrite 14 initial research, training and clinical projects named below:

- Short-term traineeships for practicing physicians;
- Post-residency traineeships in pediatric cardiology and in hypertension-renal disease;
- A visiting consultant program to community hospitals;
- Medical libraries services (interlibrary loan and photocopying);
- The Columbus (Ga.) Medical Center—Emory University affiliation for teaching;
- A communications network for the region;
- The improvement and coordination of facilities in the region for cardiovascular diagnostic services;
- A cardiopulmonary resuscitation program;
- Coronary intensive care development in small hospitals;
- Statewide cancer program;
- A cancer visiting consultant program and workshop conferences;
- Chronic pulmonary diseases;
- Medical specialty assistants;
- Community Council of the Atlanta Area (Home Health Care Program).

(The importance of continuing education can be noted in that, of the 14 projects, seven are in the area of continuing education and one-half of the total funds granted are allocated to these seven projects. The first six projects listed above, plus the cancer workshops, are the continuing education projects).

Second Grant Submitted

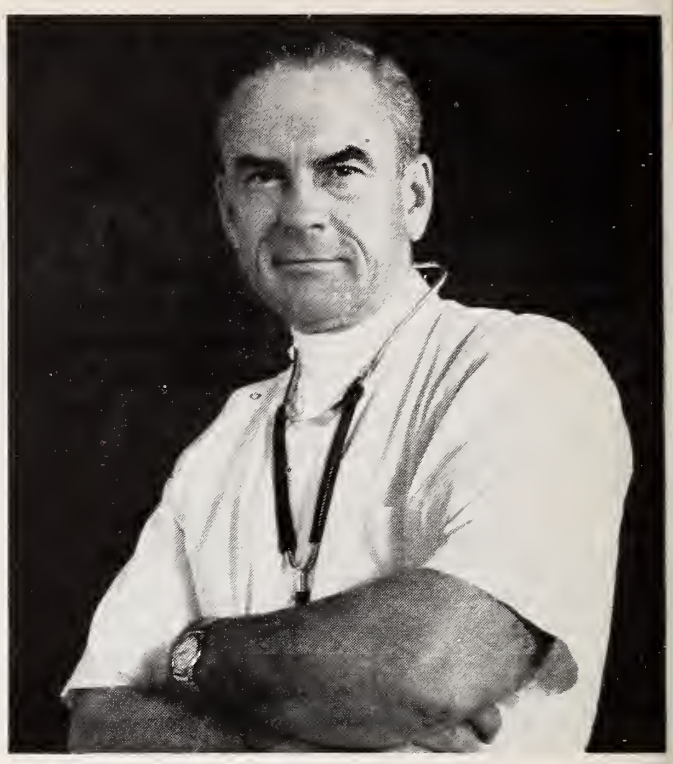
A second operational grant request to fund five additional projects which will supplement those now underway was submitted to Washington in September. No action is expected on this request until early Spring of 1969.

Meanwhile, the GRMP core staff is busy assisting in the development and implementation of the various programs. Field representatives are maintaining constant liaison with local advisory groups. Cooperative endeavors are being extended with voluntary agencies and organizations throughout the region and the task forces, which meet quarterly, are continuing to plan and coordinate future activities of the program.

First Coordinated Health-Care Program

Although health planning has been going on in this region for many years, this is the first time that representatives of all interested groups have deliberated together in an attempt to coordinate their health care planning into a unified plan for progress. The interest and participation of the practicing physicians, local hospitals and the medical schools have been excellent. Close communication with other agencies, organizations, institutions and government programs is assuring complete coordination of all activities in the area of health in the Georgia Region and the purposes of Public Law 89-239 are being achieved.

(In subsequent issues of the MAG Journal, the above named projects will be described in detail and the effect the operational grant has had on physicians and hospitals will be analyzed.)



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CORONARY ARTERY EMBOLISM

NANCY C. FLOWERS, M.D. *and* LEO G. HORAN, M.D., *Augusta*

ALTHOUGH THERE IS MUCH CONTROVERSY among clinical observers as to the prevalence of coronary artery embolism as a sequela to bacterial endocarditis, the documentation that bacterial emboli secondary to bacterial endocarditis is the leading etiology for coronary embolism is thus far irrefutable and near unanimous.

Embolization from Surgical Manipulation

It is recognized that an occasional atheromatous plaque may become dislodged and occlude a coronary radical distal to its original attachment. Rarely fragments of a bland thrombus become dislodged from the noninfected surface of rheumatic fever-damaged endocardium, and somewhat more frequently fragments of mural thrombi adherent areas of myocardial infarction become dislodged and find their way into the coronary ostia. Fragments of tumor, fat globules, particularly post-traumatically, and air emboli occur but relatively rarely. With the recent increase in the number of cardiovascular surgical procedures, the frequency of embolization from dislodged calcific material secondary to surgical manipulation may be increasing.

Bacterial Endocarditis Is Underestimated

In bacterial endocarditis, by far the most frequent etiology of coronary artery embolism, emboli commonly occlude the smaller branches of the coronary artery. The actual incidence of embolization is greater than the previous estimates of about one per cent of all coronary occlusions. Careful studies of pathologic specimens indicate frequent episodes of micro-embolization. These episodes are usually clinically inapparent unless a high index of suspicion is maintained. Symptomatic emboli with electrocardiographic changes of myocardial infarction appear to be somewhat rarer. Sudden death in this instance is common, but if the immediate effects of the embolization are survived, the prognosis for recovery is excellent.

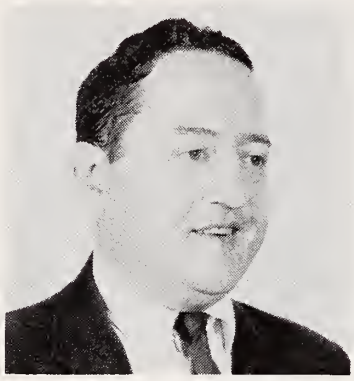
It should be emphasized that if serial electrocardiograms were obtained in every patient with bacterial endocarditis that very likely many more episodes of embolism would be revealed despite the lack of overwhelming clinical symptoms. It is not unreasonable for an otherwise normal coronary arterial network to sustain considerable insult, particularly of its more distant ramifications, without the classic manifestations of acute myocardial infarction.

Medical College of Georgia
Veterans Administration Hospital

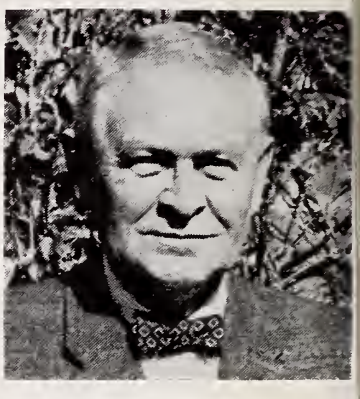
Prepared at the request of the Committee on Professional Education of the Georgia Heart Association.

COBB COUNTY MEDICAL SOCIETY TO SPONSOR SYMPOSIUM ON PROGRESS OF MAN TOWARD THE YEAR 2000

William G. Pollard



Robert P. Nenno



Joseph Fletcher

David M. Hume

The Cobb County Medical Society, through its Committee on Medicine and Religion, and Kennesaw Junior College will sponsor a symposium on "The Progress of Man Toward the Year 2000" on March 6 and 7, 1969. The program, which will be held at Kennesaw Junior College in Marietta, will begin at 8:00 p.m. on Thursday, March 6 and run through Friday evening.

The opening speaker on Thursday evening will be William G. Pollard, Ph.D., who will discuss "The Meaning of the Twentieth Century Revolution and the Status of Man in the 21st and After." This will be a scientific and theological evaluation of present and future problems such as populations, technology, etc.

Max Lerner

Dr. Pollard is Executive Director, Associated Universities of Oak Ridge, Tennessee. He is one of the world's leading nuclear physicists, and is in charge of the atomic energy facility at Oak Ridge. Dr. Pollard has been an active priest in the Episcopal church, and is author of many books.

At 9:00 p.m., Robert P. Nenno, M.D., will speak on "Perspectives in Areas of Psychiatry and Mental Health." Dr. Nenno, who is in the practice of psychiatry in Westfield, N.J., and Professor of Psychiatry at Rutgers University School of Medicine, has been a member of the faculty of Georgetown University School of Medicine, a WHO Fellow in western Europe, Professor and Chairman of the Department of Psychiatry of Seton Hall College of Medicine and a leader in the Mental Health Association of New Jersey. He was Medical Director of the New Jersey State Hospital at Marlboro from 1963-68, and is consultant on drugs for the American Medical Association.

The Friday morning session will open at 9:15 a.m., and will be sponsored by the Cobb Judicial Circuit Bar Association. A lawyer, to be named, will speak on "Perspectives in Areas of Law."

"Perspectives in Areas of Theological Aspects—Especially as Related to Medicine and Law" will be the topic of a talk by Joseph Fletcher, S.T.D., D.D. Dr. Fletcher, the Robert Treat Paine Professor of Social Ethics in the Episcopal Theological School, Cambridge, Mass., has been Dean of the Cathedral of Cincinnati, Dean of the Graduate School of Applied Religion in Cincinnati, and president of the American Society for Christian Ethics. He is the author of numerous books, including *Situation Ethics* and *Moral Responsibility*.

David M. Hume, M.D., will speak on "Perspectives in Areas of Medical Advances" which will include comments on such procedures as organ transplantation, etc. Dr. Hume is Professor of Surgery and Chairman of the Department of Surgery at the Medical College of Virginia in Richmond, and surgeon-in-chief at the VA Hospital there. He has been actively involved in organ transplantations, and has written extensively on the subject, especially regarding kidney transplants.

Max Lerner, Ph.D., will present a comprehensive discussion of the entire symposium subject. Dr. Lerner is an author, teacher, and journalist, and currently is professor of American Civilization and World Politics at Brandeis University.

This program has been approved for nine hours credit by the American Academy of General Practice. The Thursday and Friday evening sessions are open to the public. Friday morning and afternoon sessions are limited to physicians, lawyers, and clergymen, their wives, nurses and allied medical personnel, students of medical, law and theology schools, and individuals in special fields of education.

For detailed information and registration blanks, write Symposium '69, Office of Public Information and Continuing Education, Kennesaw Junior College, Marietta, Georgia 30060.

NEW MEMBERS

Anderson, Grover L., M.D. Active—Fulton	2583 Woodtrail Lane Decatur, Georgia 30033
Boyette, David M., M.D. Active—Bibb	829 First Street Macon, Georgia 31201
Brown, Frank J., M.D. Active—Fulton	22 Ramsey Street Roswell, Georgia 30075
Fellner, Donald W., M.D. Active—Fulton	1311 Cleveland Avenue East Point, Georgia 30044
Fiedotin, Arnoldo, M.D. Active—Fulton	265 Ivy Street, N.E. Atlanta, Georgia 30303
Forsyth, Douglas H., M.D. DE-2—Fulton	69 Butler Street, S.E. Atlanta, Georgia 30303
French, James B., M.D. Active—Hall	1100 Vine Street Gainesville, Georgia 30501
Gomez, Frank, M.D. Active—Fulton	2315 Dorsey Avenue East Point, Georgia 30044
Jennings, Jane B., M.D. Active—Georgia Medical	Memorial Medical Center Savannah, Georgia 31404
Lane, Richard A., M.D. Active—DeKalb	2508 Carroll Avenue Chamblee, Georgia 30005
Morris, Larry A., M.D. Active—Hall	274 Enota Drive Gainesville, Georgia 30501
Neistadt, Arnold, M.D. Active—Fulton	1285 Peachtree St., N.E. Atlanta, Georgia 30309
Ribis, Samuel J., M.D. Active—Walton	Loganville Medical Clinic Loganville, Georgia 30249
Rountree, Clyde B., M.D. Active—Fulton	1325 W. Peachtree Street, N.W. Atlanta, Georgia 30309
Scarbrough, Roger W., Jr., M.D. Active—Georgia Medical	2 Medical Arts Center Savannah, Georgia 31405
Thompson, Wilbur J., M.D. Active—Hall	Nalley Luke Building Gainesville, Georgia 30501

SOCIETIES

At the September 14 meeting of the **Hall County Medical Society,** Dr. Julian Jacobs discussed "Malaria —1968: The Importance of Malaria to the American Physician."

Robert Ellison, M.D., of the Medical College of Georgia, was the guest speaker at the scientific meeting of the **Richmond County Medical Society** held October 22. The topic of Dr. Ellison's talk was "Cardiac Transplants."

Members of the **Dougherty County Medical Society** have endorsed plans for a new hospital to be built in Albany. Thomas F. Frist, M.D., president of the Hospital Corporation of America, based at Nashville, Tenn., told of plans to build a 150-200 bed private hospital in Albany with corporate funds. Members of the Society supported the idea, and a steering committee of local physicians is now working with the Nashville group to develop the plans.

The **Third District Medical Society** held its fall meeting on October 17 in Cuthbert. Guest speakers included George Hunter, M.D., who spoke on "Internal Derangement of the Knee," Ross F. Neisula, M.D., who discussed "Government Family Planning Efforts in Georgia," and Frank A. Wilson, III, M.D., whose topic was "Rebellion of Youth: History and Background."

A panel discussion on medical trends over the next 25 years was the subject at the October 8 meeting of the **Georgia Medical Society.** Dr. J. Gordon Barrow, director of the Georgia Regional Medical Program, and Dr. Glen Garrison, professor and chairman of the Department of Community Medicine of the Medical College of Georgia were featured speakers.

On November 12, the Society was the guest of the Savannah Bar Association. Members heard Frank Schaub speak on "The Significance of Medical Testimony." Mr. Schaub is the State Attorney from Bradenton, Florida who defeated Defense Attorney, F. Lee Bailey in the Coppolino trial.

The Georgia Medical Society also has agreed to conduct a program of education on drug abuse in local public high schools and junior high schools at the request of the Board of Education.

The October meeting of the **Muscogee County Medical Society** featured noted author and physician Dr. Paul Williamson of Andalusia, Alabama. Dr. Williamson writes for the Magazine Practice which is published by Savage Laboratories.

PERSONALS

First District

James L. Alexander has been named to organize and head a committee which will represent the Savannah area in all transactions with the Director of the Regional Medical Program.

The new president of the Savannah branch of the Arthritis Foundation is **J. Reid Broderick.** Dr. Broderick served for two years as medical vice-president, and has been succeeded in that position by **William C. Rhangos.** Foundation directors include **Wesley J. Ball** and **Julian Kelly.**

The new chairman of the Red Cross First Aid Committee is **Dan Cox.** Dr. Cox is also director of medical education at Memorial Medical Center.

The new president of the Georgia State Medical Association is **Stephen M. McDew** of Savannah.

Third District

Perry physican **J. R. Arnall** has been appointed a member of the Houston County Board of Education.

New medical staff officers at R. J. Taylor Memorial Hospital in Hawkinsville include Chief-of-Staff **Hart Sylvester;** vice-chief-of-staff **W. E. Coleman;** and secretary-treasurer **W. R. Baker,** all of Hawkinsville.

Fifth District

On January 1, 1969, **James N. Brawner, Jr.** will retire from the active medical staff and from the position of Medical Director of Brawner Hospital at Smyrna. Dr. Brawner will open his office for continuation of the practice of psychiatry at the Sea Pines Medical Center, Hilton Head Island, S.C. He will maintain his personal interest in the operation of the hospital as a member of the Board of Directors.

Mark A. Gould will become the new Medical Director.

Mieczyslaw Peszczynski of Fulton County has been elected vice-president of the Society of Academic Physiatrists.

John D. Thompson has been elected to the Executive Council of the Association of Professors of Obstetrics-Gynecology at Emory University.

Raimundo J. Ramirez has been certified as a Fellow in the American College of Anesthesiologists.

Participants in the recent annual meeting of the South Carolina Orthopedic Association included **Joseph Dimon** and **Grady Clinkscales.**

The new president-elect of the American Society of Anesthesiologists is **John E. Steinhaus.** Dr. Steinhaus is professor and chairman of the Department of Anesthesiology at Emory University School of Medicine.

Eighth District

J. E. Smith of Fitzgerald was a featured speaker at the October 8 meeting of the Fitzgerald Rotary Club. Dr. Smith pointed out the urgent need for a new 60-bed hospital in the area to avoid "potential disaster."

Ninth District

One of the stars of "Oliver!," which was presented by the Gainesville Civic Theater in November, was **C. Leonard Geiger.** Dr. Geiger is a pathologist at Hall County Hospital, and played the part of Mr. Bumble, director of the orphanage in the musical based on Charles Dicken's "Oliver Twist."

Tenth District

The American College of Surgeons presented an award to **William H. Moretz** and **Charles H. Wray** for a teaching film they co-authored. Dr. Moretz and Dr. Wray collaborated with a third member of the faculty at the Medical College of Georgia to produce the film "Prevention of Pulmonary Embolism by Partial Occlusion of the Inferior Vena Cava."

George McInnes of Augusta spoke before the October meeting of the Women's Board of University Hospital. The subject of his talk was the "Volunteer in Vietnam."

DEATHS

Thomas Hudson Brabson

Cornelia physician Thomas Hudson Brabson died in Habersham County Hospital at the age of 86, following a three-week illness.

Dr. Brabson, a native of Macon County, N.C. had practiced in Cornelia for more than 50 years.

Survivors include a foster daughter, Mrs. Olin E. Mcneeley, Clemson, S.C.; a step-son, O. Prince Ayers, Savannah; two brothers, John M. Brabson, Demorest, and Maurice Brabson, Franklin, N.C.; a sister, Mrs. Blance Bulgin, Franklin, N.C., and four grandchildren.

Herbert Carl Schenck

Graveside services for Herbert Carl Schenck of Macon were held on October 14 in Riverside Cemetery.

Dr. Schenck had been a director emeritus of the Georgia division of TB Control for 25 years, and was president of the Georgia Tuberculosis Association. He was also a former president of the Southern TB Conference, and a former Georgia member of the board of directors of the National TB Association.

Survivors include his wife, the former Edwina Little; a daughter, Mrs. Joseph E. Day, Tulsa, Okla.; and two sisters, Mrs. William A. Stienle, Salina, Kan., and Mrs. Carl E. Mitchell, Burbank, Calif.

W. Wycliffe Hillis

W. Wycliffe Hillis, Sr., 84, who practiced medicine in Sardis for 60 years, died October 19 after a short illness.

A native of Burke County, Dr. Hillis was the last surviving member of the class of 1909 at the University of Georgia Medical College. He was a former member of the school board in Sardis, a Mason, and a member of the Tri-County Medical Association.

Surviving are his wife, Mrs. Mildred Kent Hillis of Sardis; a daughter, Mrs. Alan Sherrill of Atmore, Ala.; a son, Dr. W. W. Hillis, Jr. of Millen; two sisters, Mrs. Irene Hankinson of Sylvania and Pauline Hillis of Girard; three brothers, C. K. Hillis of Jacksonville, Fla., R. L. Hillis of Girard, and Dr. J. W. Hillis of Millen, and six grandchildren.

David R. Thomas, Jr.

Prominent Augusta physician David R. Thomas, Jr., died September 28 in Charleston, S.C.

A native of Tennille, Ga., Dr. Thomas was graduated from Virginia Military Institute in 1926 and from the Medical College of Georgia in 1930. During World War II he served in the U.S. Army Medical Corps in

the China-Burma-India theatre. He returned to Augusta in 1946 to resume private practice.

Dr. Thomas was a member and past president of the Southeastern Allergy Association, member and past president of the Richmond County Medical Society, chairman of the board of Insurance and Economics of the Medical Association of Georgia and a member of the board of Directors of Blue Cross and Blue Shield. He had served on the faculty of the Medical College of Georgia since 1946, and at the time of his death, he was a professor of Clinical Medicine there.

Survivors include his wife, Mrs. Adelaide Croft Thomas; two sons Dr. David R. Thomas, III, and Randell Croft Thomas, Atlanta; and a brother, Dr. J. Warrick Thomas, Richmond, Va.

THE MONTH IN WASHINGTON

Three-fourths of the medicare Part B carriers now are using individual physician fee profiles in determining reasonable charges.

The Social Security Administration said that these carriers, a total of 36, collectively process 80 per cent of the medicare bills submitted by physicians. Prevailing fees continue as a major factor in the reasonable charges determined by the carriers.

The remaining 14 carriers which have not yet fully developed the individual physician fee profiles, or the computer capacity for using them, are employing other interim techniques. Some use, in addition to prevailing fees, fee schedules; others, relative value scales, or similar techniques, in determining reasonable charges.

Hospital Coverage Raised

The medicare hospital deductible will be increased from $40 to $44 January 1, 1969. The law specifies that if an annual review shows that hospital costs have changed significantly, the hospital deductible amount must be adjusted for the following year.

Cost of Medical Care

The shortage of physicians, particularly general practitioners, was cited in a government report as a factor in the increase in physicians' fees since World War II.

Rise in Physicians' Fees

The report said that physicians' fees, while not advancing as rapidly as hospital charges, had more than doubled in the past 10 years. Hospital charges more than quadrupled.

"The rise in physicians' fees during the 1946-67 period is partially due to the general rise in price levels and to the physicians' need for increased income to cover his personal and business costs," the report said.

Physician Shortage Is Factor

"This is especially true for the past two years. Doctors have tended to attribute their higher fees in recent years to the general economic conditions and the higher cost of doing business. Nevertheless, some charges clearly reflect the shortage of doctors. With an overload of patients, physicians in some cases have tried to discourage the practice of making house calls by raising the rate for such a service to a level that few patients are willing to pay. The postwar emphasis on medical specialists has also helped to boost physicians' fees since general practitioners have become scarce and specialists, with their extra training are able to command higher fees."

Quality Is Overlooked

The BLS conceded that its reports on health care costs do not give adequate consideration to improvements in the quality of medical care as reflected in longer life spans, improved and more efficient techniques for treatment, shorter hospital stays, etc.

Illegal Drug Traffic

President Johnson signed into law a bill providing for tougher penalties for illegal traffic in amphetamines and barbiturates. LSD also is covered specifically.

The new law makes illegal possession, manufacture or disposal of the drugs a misdemeanor carrying maximum penalties ranging from imprisonment of one year and a fine of $1,000 to imprisonment of 15 years and a fine of $20,000. Leniency is authorized for first offenders.

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CALENDAR OF MEETINGS

In Georgia

February 18-22, 1969—American College of Radiology, Regency-Hyatt House, Atlanta.

February 23-26—Atlanta Graduate Medical Assembly, Regency-Hyatt House, Atlanta.

March 14-15—American Burn Association, Regency-Hyatt House, Atlanta.

May 4-7—115th MAG Annual Session, Savannah Inn and Country Club, Savannah.

National

December 13-15—American Academy of Psychoanalysis, Royal Orleans Hotel, New Orleans, La.

December 20-22—American Psychoanalytic Association, Waldorf Astoria Hotel, New York, N.Y.

1969

January 17-18—American Society for Surgery of the Hand, Americana Hotel, New York, N.Y.

January 18-23—American Academy of Orthopaedic Surgeons, Americana Hotel, New York, N.Y.

January 22-24—Frontiers of Medicine 1969 (Sponsored by Lakeland Graduate Medical Assembly; cosponsored by Staff of Winter Haven Hospital and Florida Academy of General Practice), Sheraton Motor Inn, Winter Haven, Fla.

January 23-25—Southern Society of Clinical Investigation, Jung Hotel, New Orleans, La.

January 31-February 2—Southern Radiological Conference, Grand Hotel, Point Clear, Ala.

February 5-7—American Academy of Occupational Medicine, Sheraton Plaza Hotel, Boston, Mass.

February 8-13—International Academy of Proctology (Annual Congress and Teaching Seminar), Hollywood Beach Hotel, Hollywood, Fla.

February 9-10—Congress on Medical Education, Palmer House, Chicago, Ill.

February 13-15—Society of University Surgeons, Hotel Fontainebleau, Miami Beach, Fla.

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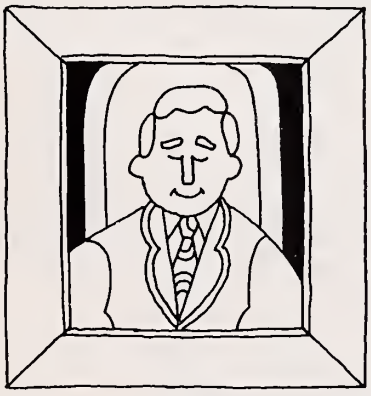

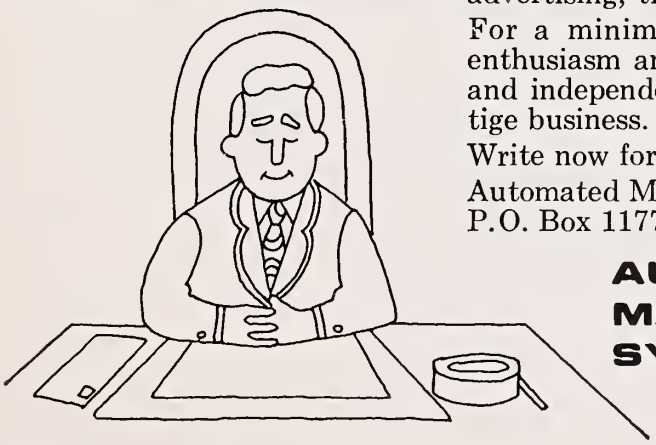

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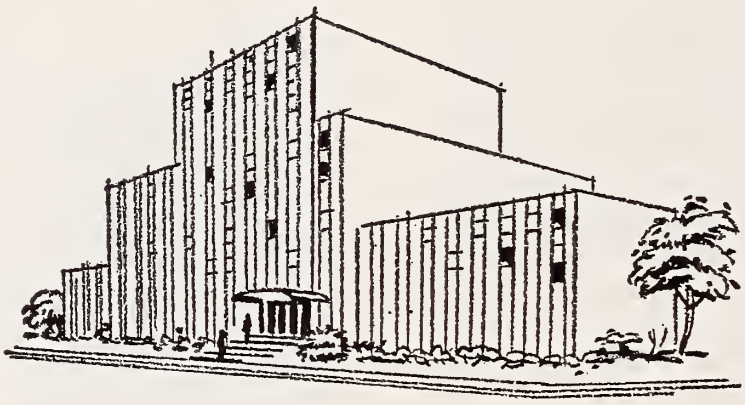

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Ponce de Leon Infirmary

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